SBHG EMR Training
Phase I
User's Guide

PART I – EVOLV SYSTEM CONVENTIONS

PART II – ENTERING A SERVICE

Volume IV
Release Date 2.8.09

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PART I – EVOLV SYSTEM CONVENTIONS

After completing this section, you will be able to:

1. Login to the System
2. Understand the Browser Interface
3. Identify Components of the Evolv-CS Workspace
4. Navigate through Modules in the Evolv-CS System

SYSTEM LOG-ON

As with all database systems, you will have to log on to the system to identify yourself.

To open the EMR portal page from within a SBHG location, type "EMR" into an Internet Explorer browser window.

HOME USE

To open the EMR portal page outside the SBHG network (i.e. working from home) type into an Internet Explorer browser window https://icmsweb.starsinc.com
If you have difficulties logging into the EMR from a computer that is not an SBHG/Starview computer you will need to reference the **Home User's Guide located in your EMR Manual. The EMR and IT team is not allowed to help staff with computer issues outside the SBHG network.

NOTE: After you are finished with training and begin using the EMR to document actual services, make sure you are logged in the live environment.

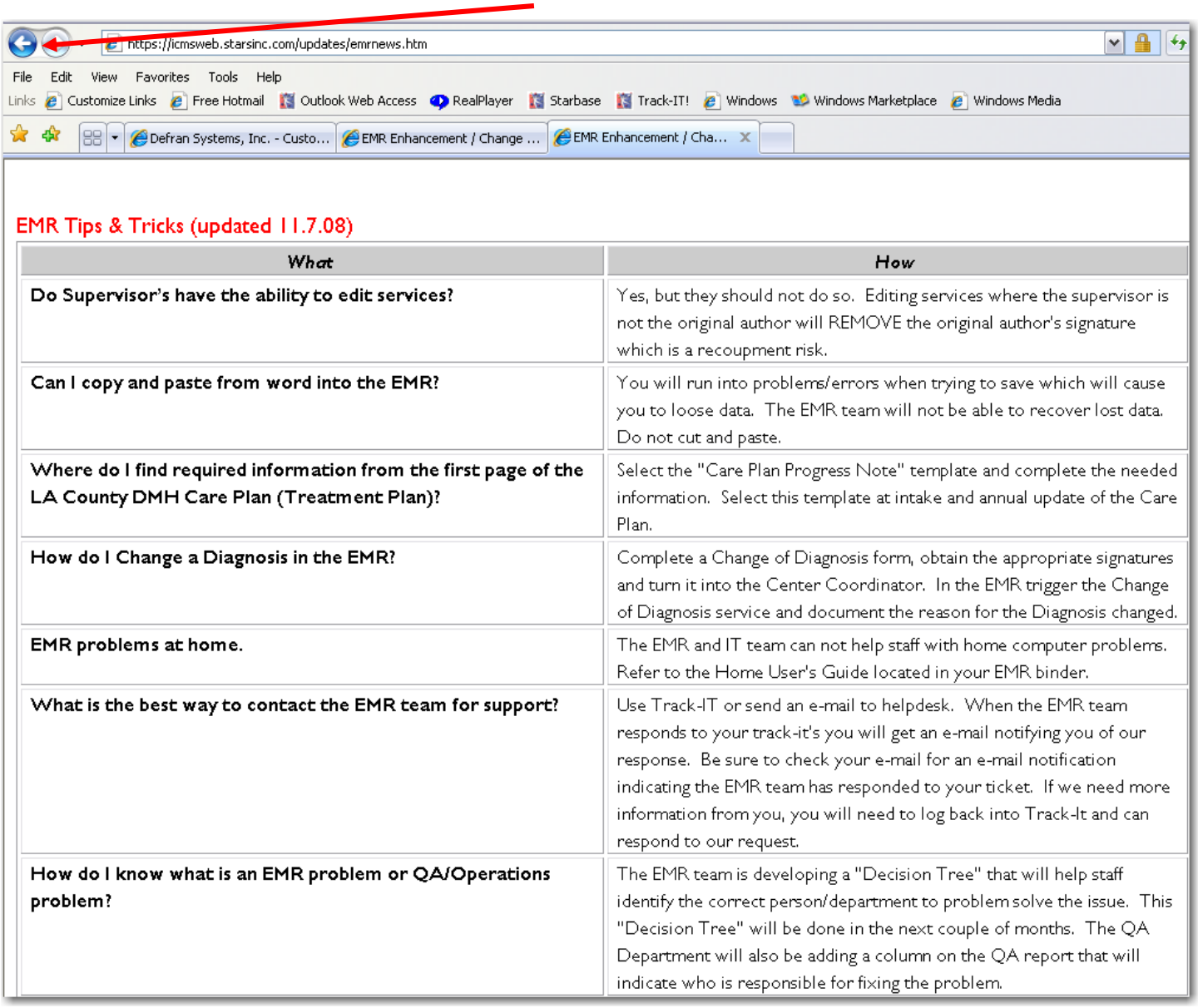
CHECKING THE EMR LATEST NEWS AND UPDATE LINK

Click on the link listed below. Check this link often for the latest news and updates with the EMR. This is the EMR Teams way to communicate with all staff.

When you click on the link a new Internet Explorer page will open. Scroll down the page and review the information. There are three sections to the Update Page:

- EMR Tips & Tricks
- EMR Myths
- EMR Enhancements

To return to the EMR portal page click the Internet Brower back button.


https://icmsweb.starsinc.com/updates/emrnews.htm
File Edit View Favorites Tools Help
Links Customize Links Free Hotmail Outlook Web Access RealPlayer Starbase Track-IT! Windows Windows Marketplace Windows Media
Defran Systems, Inc. - Custo...
EMR Enhancement / Change ...
EMR Enhancement / Cha...

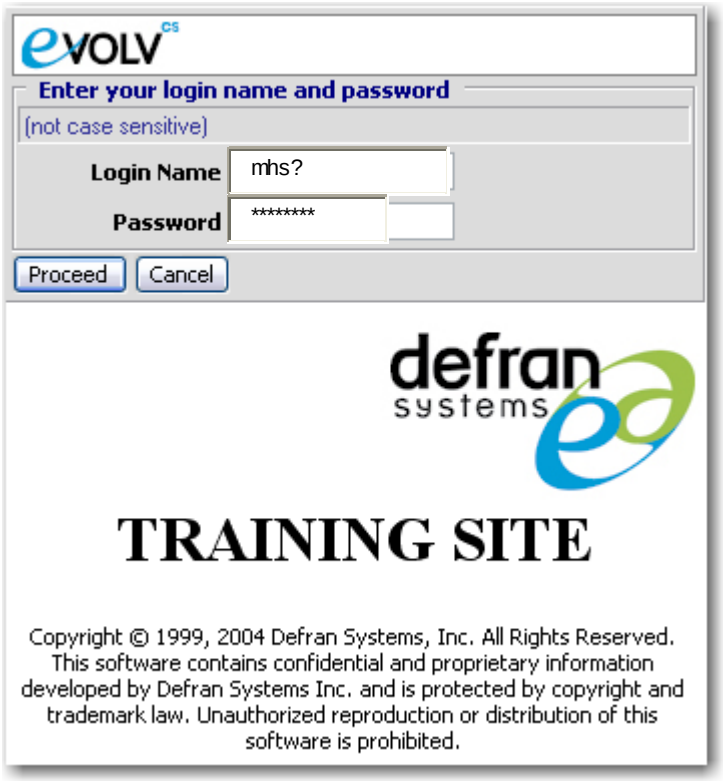
EMR Tips & Tricks (updated 11.7.08)

What	How
Do Supervisor's have the ability to edit services?	Yes, but they should not do so. Editing services where the supervisor is not the original author will REMOVE the original author's signature which is a recoupment risk.
Can I copy and paste from word into the EMR?	You will run into problems/errors when trying to save which will cause you to loose data. The EMR team will not be able to recover lost data. Do not cut and paste.
Where do I find required information from the first page of the LA County DMH Care Plan (Treatment Plan)?	Select the "Care Plan Progress Note" template and complete the needed information. Select this template at intake and annual update of the Care Plan.
How do I Change a Diagnosis in the EMR?	Complete a Change of Diagnosis form, obtain the appropriate signatures and turn it into the Center Coordinator. In the EMR trigger the Change of Diagnosis service and document the reason for the Diagnosis changed.
EMR problems at home.	The EMR and IT team can not help staff with home computer problems. Refer to the Home User's Guide located in your EMR binder.
What is the best way to contact the EMR team for support?	Use Track-IT or send an e-mail to helpdesk. When the EMR team responds to your track-it's you will get an e-mail notifying you of our response. Be sure to check your e-mail for an e-mail notification indicating the EMR team has responded to your ticket. If we need more information from you, you will need to log back into Track-It and can respond to our request.
How do I know what is an EMR problem or QA/Operations problem?	The EMR team is developing a "Decision Tree" that will help staff identify the correct person/department to problem solve the issue. This "Decision Tree" will be done in the next couple of months. The QA Department will also be adding a column on the QA report that will indicate who is responsible for fixing the problem.

LOGGING INTO THE EMR

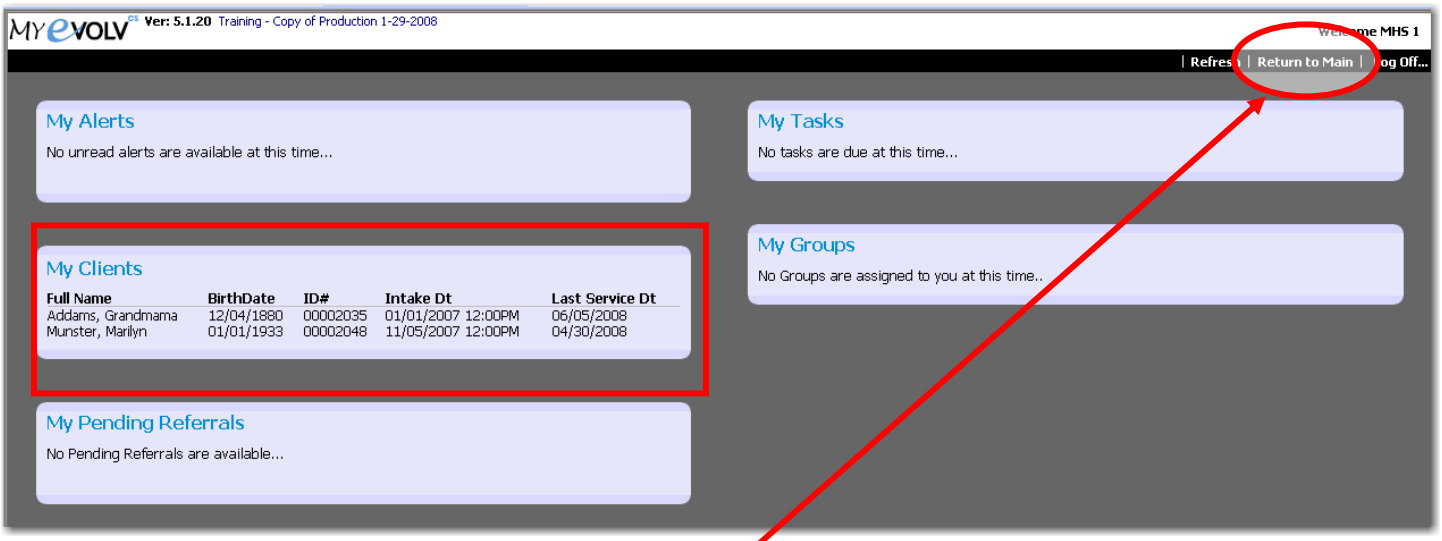
For the purposes of this training click on the Training Environment on the EMR portal page; the login page will open.

Your training material has your logon name and password to enter into the logon screen for the training EMR.


eVOLV cs
Enter your login name and password
(not case sensitive)
Login Name
mhs?
Password
****
Proceed
Cancel
defran systems
TRAINING SITE
Copyright © 1999, 2004 Defran Systems, Inc. All Rights Reserved.
This software contains confidential and proprietary information developed by Defran Systems Inc. and is protected by copyright and trademark law. Unauthorized reproduction or distribution of this software is prohibited.

	Login Name:	**mhs?**
	Password:	**password**
	Click	Proceed

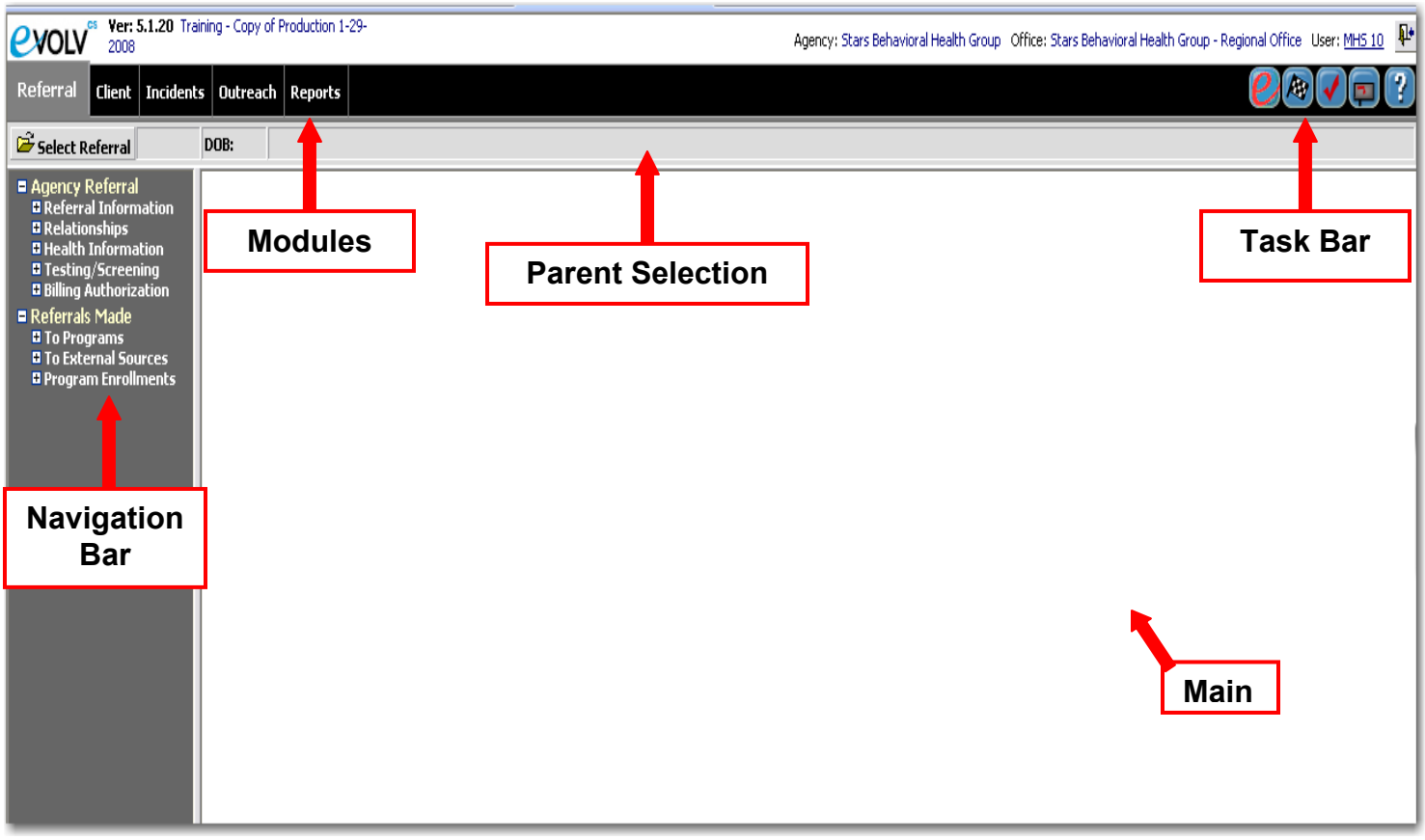
When you login, you'll immediately see your "My Evolv" page. This will be your site navigation short cut page. For more information regarding "My Evolv" page please reference the "Other EMR Functions Manual". But first let's get familiar with the components of the Evolv-CS Workspace.


MY EVOLV Ver: 5.1.20 Training - Copy of Production 1-29-2008
Welcome MHS 1
Refresh | Return to Main | Log Off...
My Alerts
No unread alerts are available at this time...
My Tasks
No tasks are due at this time...
My Clients
Full Name BirthDate ID# Intake Dt Last Service Dt
Addams, Grandmama 12/04/1880 00002035 01/01/2007 12:00PM 06/05/2008
Munster, Marilyn 01/01/1933 00002048 11/05/2007 12:00PM 04/30/2008
My Groups
No Groups are assigned to you at this time..
My Pending Referrals
No Pending Referrals are available...

Look at the top of the page and click on "Return to Main".

BASIC NAVIGATION

This section will demonstrate how to move around the system. It will introduce some basic terminology essential to the operation by all levels of users including administrators through intake workers.



MODULES

Each **MODULE** represents a point of entry for a separate business function. Some of the information may be repeated from one module to another, i.e. Referral personal demographics would be the same information in Client personal demographics. Updating one area will filter to other areas.

The module you are currently working in will appear in gray with a slightly larger font:

Active Module: Referral

All inactive modules will have a black background and slightly smaller font:

Module: Referral

When you first login to the main interface you will be defaulted to the REFERRAL MODULE (tab) on the Parent Selection Bar. You could locate your client in the referral module however you will not be able to capture billable services provided.

The **PARENT SELECTION BAR** indicates the client's name and demographic information. Beneath the Parent Selection Bar in the Main section will be information regarding the client, family, incident, etc.

Click on the **CLIENT MODULE** (tab). Notice the client module (tab) is now grey and bigger font.

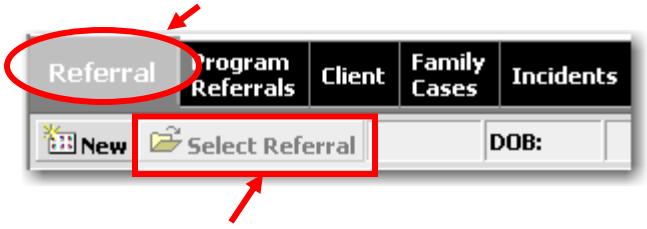
The **CLIENT MODULE** is used to access and track information about people who are clients. Some of the following pieces of information can be accessed through this module.

- Client Personal Information
- Treatment History
- Worker Assignments
- Enrollment Information
- Document Billable and Non-Billable Services
- Complete Forms

NOTE: notice that under the Referral Module it states "Select Referral" vs. under the Client Module it states "Select Client"

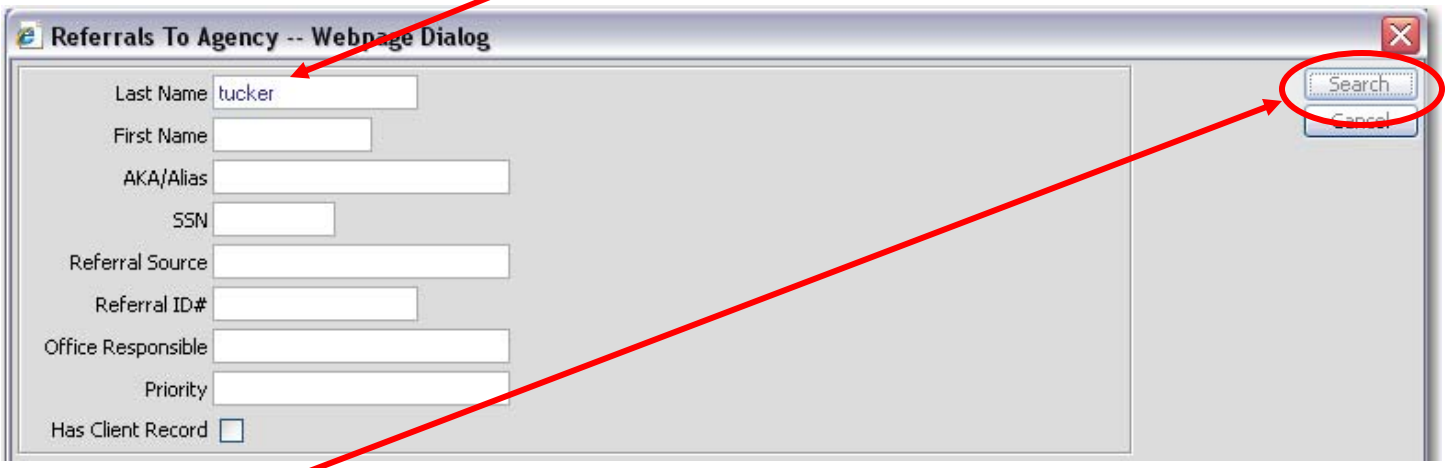
DOCUMENTING NON-BILLABLE SERVICES ON A REFERRAL

To document a NON-BILLABLE N/C note on a Referral (someone who is NOT a client) click on the Referral Module



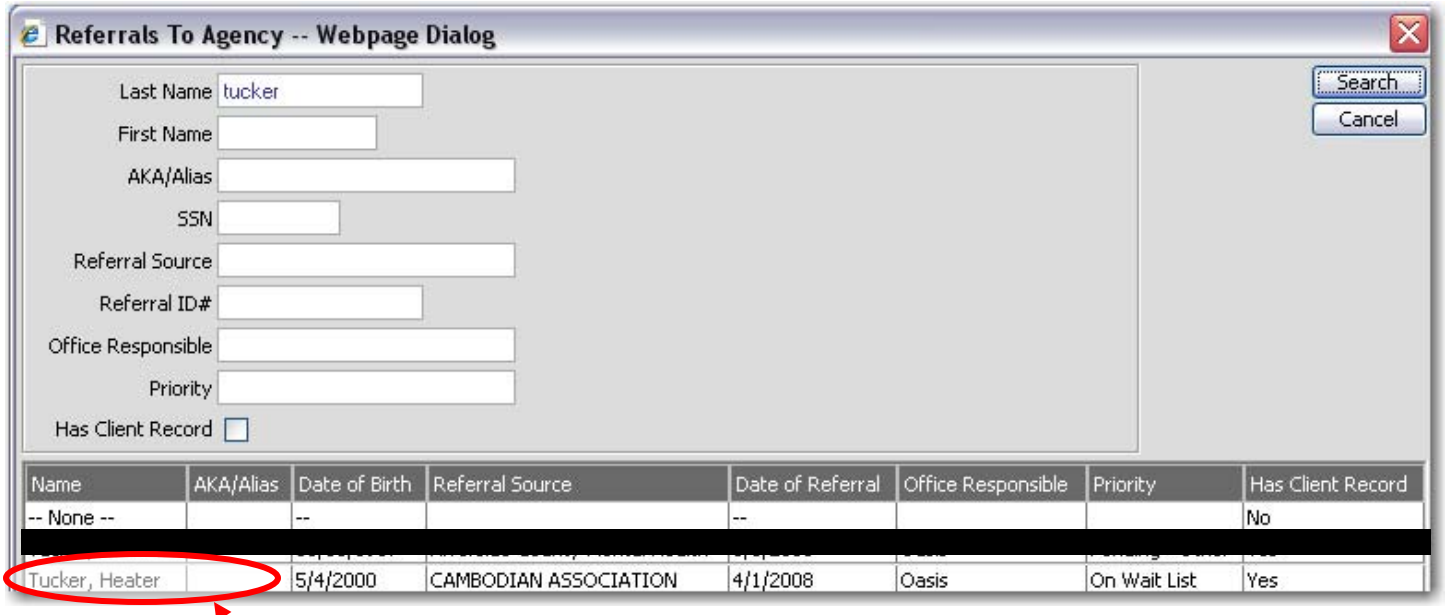
Click "Select Referral"

A Search box will open. Type in the name of the Referral



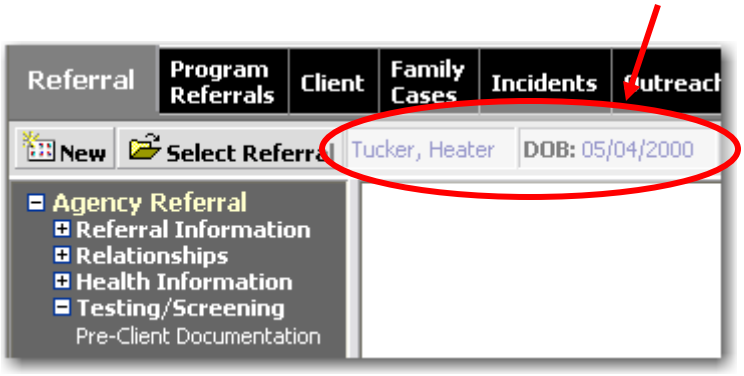
Click "Search"

The name of the Referral will show on the bottom of the search box

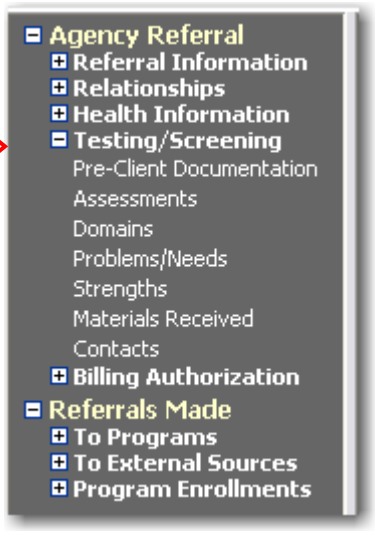


Click on the Name of the Referral

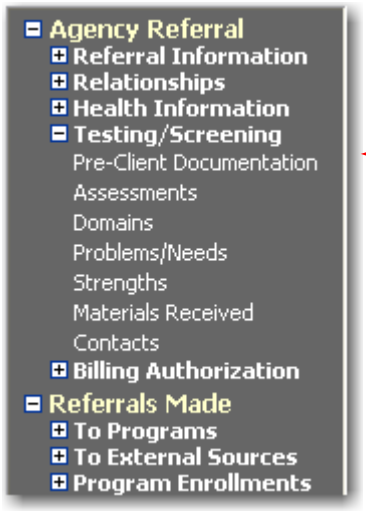
Notice the Referral name in the Parent Selection Bar



Under Agency Referral click the + sign next to Testing/Screening



Click on Pre-Client Documentation



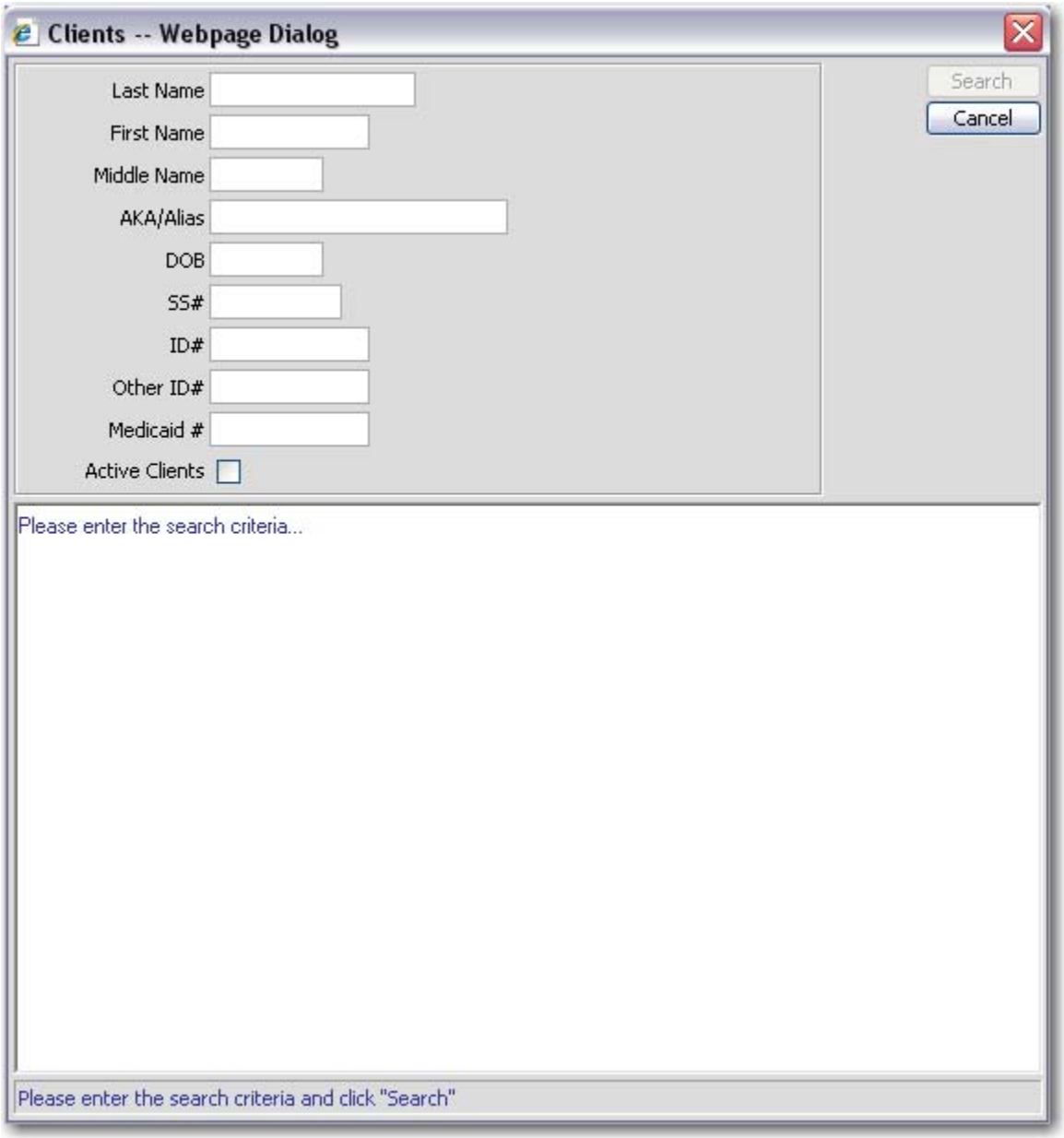
Follow instructions on page 16 on how to fill out a service

NOTE: Documenting NON-Billable services on a Referral should be done ONLY if the Referral is NOT an active client. If the Referral IS an active client review the next section on how to find and complete a service on a client

PART II - OPENING A CLIENT RECORD

First click the select client button

The following screen appears:



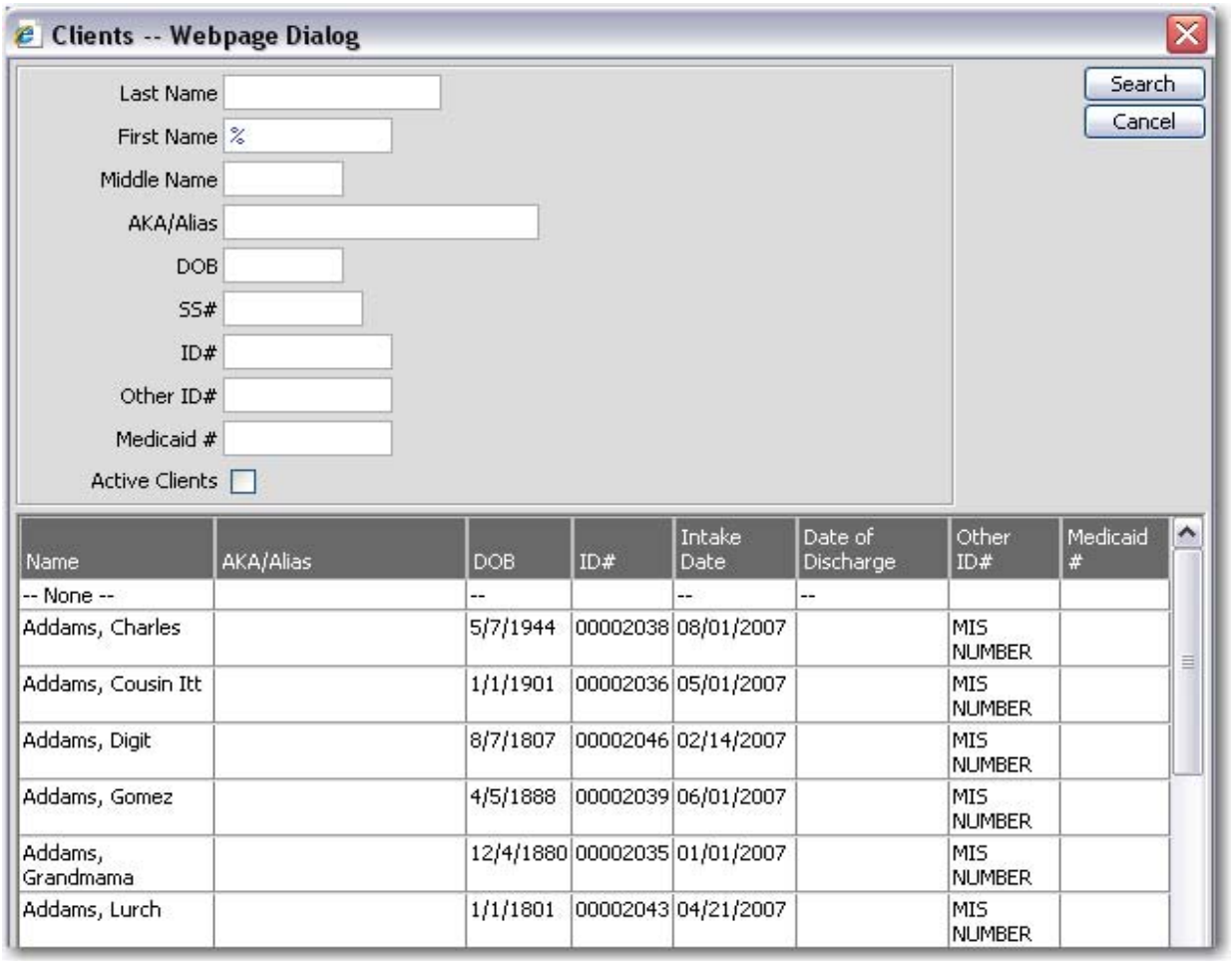
This is how and where you're going to locate your client and their information.

When conducting searches in Evolv-CS, you can type in full criteria, such as an entire last name, social security number, etc.

Typing in just a few letters of the client's first or last name (not case sensitive) will pull up all clients on your team whose name begins with those letters.

However, if you don't know the spelling of a client's name you can narrow down the search by using the percentage (%) symbol typed in the last name or first name field.

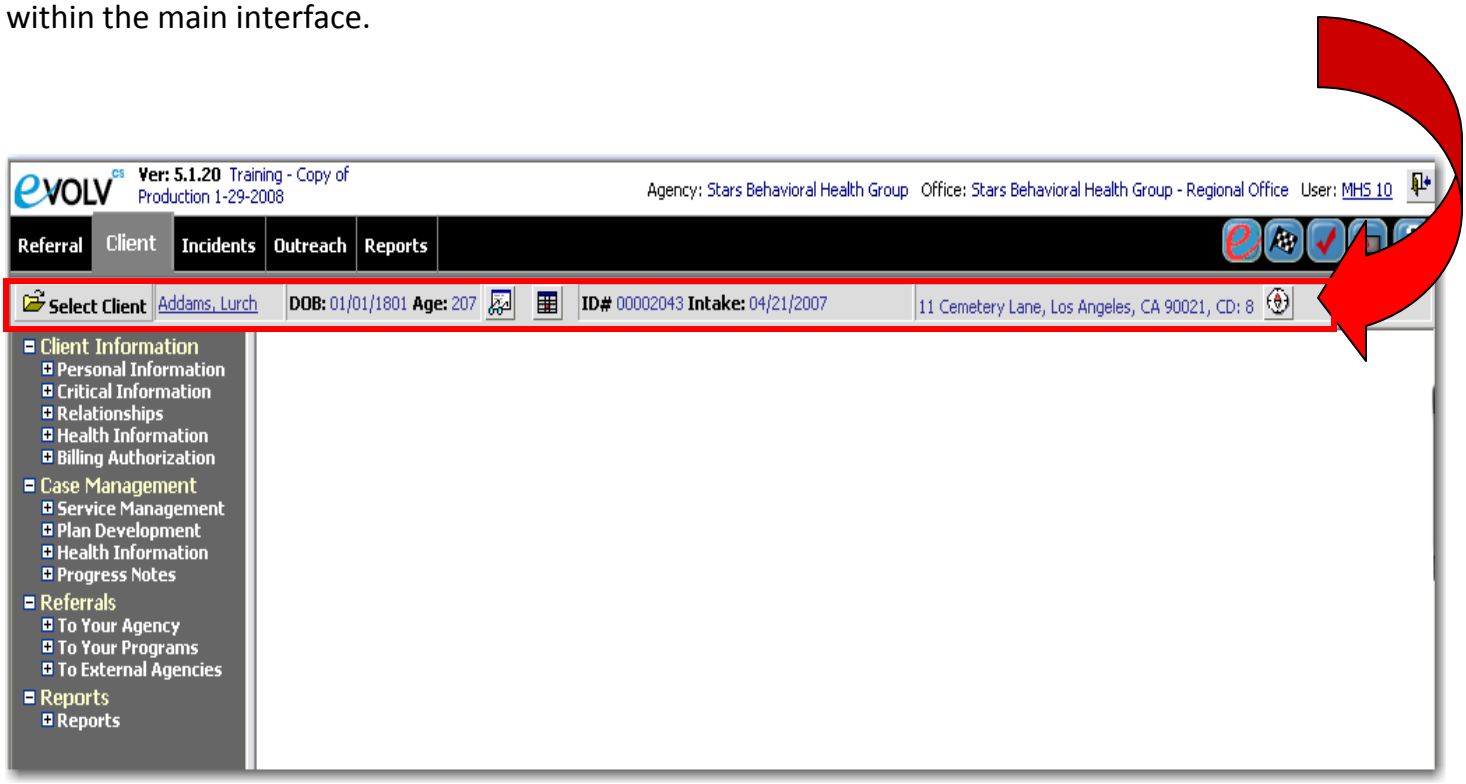
- **Typing in just the percentage symbol will pull up all the clients on your team.**
- **Typing in the percentage symbol and any letter will pull up any client's who have those letters in their name.**
- **For additional information see Search Tips on page 31 of this Guide.**


Clients -- Webpage Dialog
Last Name
First Name %
Middle Name
AKA/Alias
DOB
SS#
ID#
Other ID#
Medicaid #
Active Clients
Search
Cancel
Name | AKA/Alias | DOB | ID# | Intake Date | Date of Discharge | Other ID# | Medicaid #
-- None -- | | -- | | -- | -- | | |
Addams, Charles | | 5/7/1944 | 00002038 | 08/01/2007 | | MIS NUMBER | |
Addams, Cousin Itt | | 1/1/1901 | 00002036 | 05/01/2007 | | MIS NUMBER | |
Addams, Digit | | 8/7/1807 | 00002046 | 02/14/2007 | | MIS NUMBER | |
Addams, Gomez | | 4/5/1888 | 00002039 | 06/01/2007 | | MIS NUMBER | |
Addams, Grandmama | | 12/4/1880 | 00002035 | 01/01/2007 | | MIS NUMBER | |
Addams, Lurch | | 1/1/1801 | 00002043 | 04/21/2007 | | MIS NUMBER | |

SELECTING A CLIENT

Locate your training client and click on their name.

Notice the client's name and demographic information now populates in the parent selection bar within the main interface.



DETERMINING IF TREATMENT PLAN AND/OR COLLATERALS ARE ON FILE IN THE EMR

Determining if there is a Treatment Plan:

1. On the navigation bar under Case Management click on Plan Development
2. Click on Treatment Plan
3. If there is not a Treatment Plan you will see <Start New Plan>, if there is a Treatment Plan you will see either CMHS Initial or CMHS Review
4. This indicates that there is at least one objective on file.

Determining if there is Collateral Information:

1. On the navigation bar under Client Information click on Relationships
2. Click on Collaterals
3. If there is not Collateral Information you will see No Information Found, if there is Collateral Information you will see a list of Collateral name(s)
4. Verify the Collateral you will be referencing in your progress note is listed

Knowing if this information is on file will impact which format you will use when writing a progress note.

PART II – ENTERING A SERVICE / PROGRESS NOTES

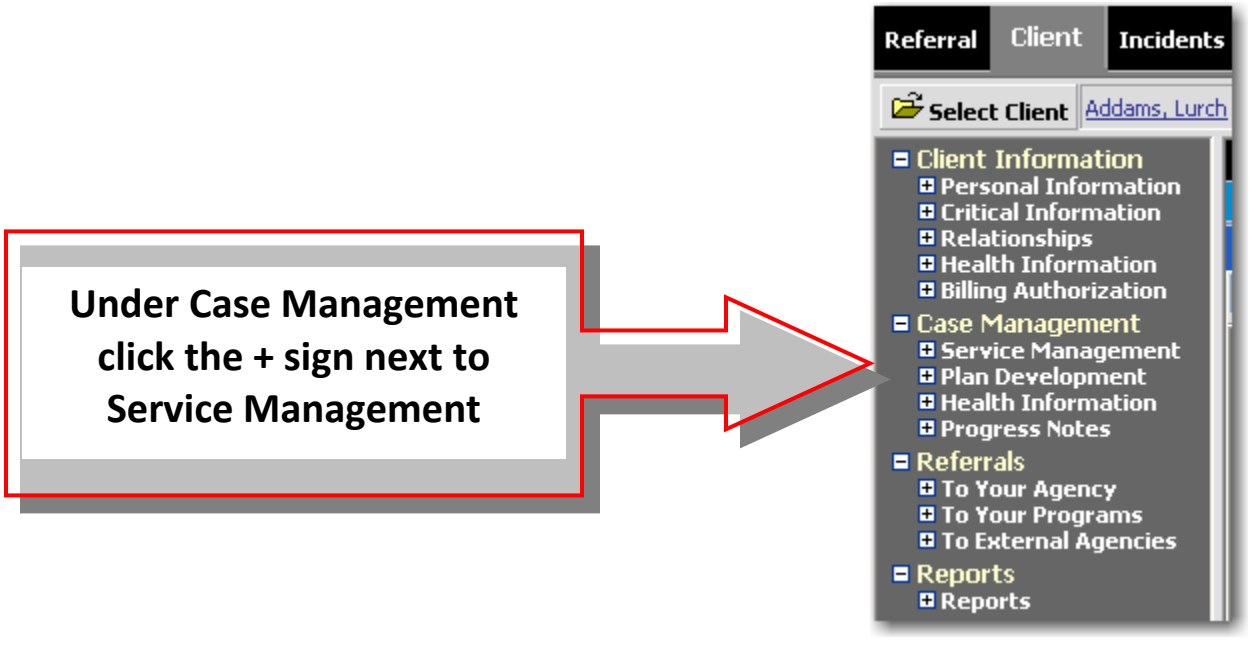
After completing this section, you will be able to:

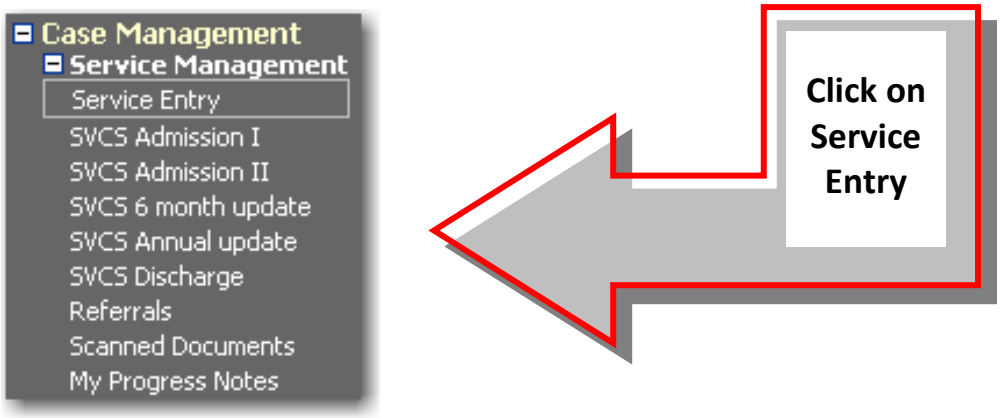
1. Navigate through the Client Module
2. Understand the navigation bar
3. Enter a simple service on a client

ENTERING A SERVICE WITHIN THE CLIENT MODULE

Now that you have selected your client you are to ready enter a service. All services provided for any client are housed under the Client Module and are located within Service Management in the Navigation Bar.

The service entry is the equivalent of the progress note section of a chart.

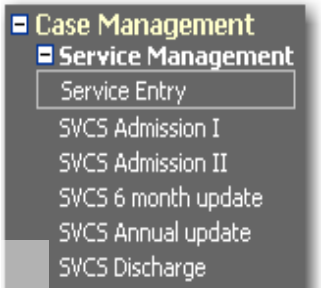




A closer Look at Navigation access within Service Management.

Here is a list of forms/services under Service Management for MHS II access:

NOTE: MHS I and Support Counselor level access will differ based on Scope of Practice.



SVCS Admission I

- Coordination Plan
- Provisional Care Plan

SVCS Admission II

- 3 - page Child Assessment
- Adult Initial Assessment
- CAFAS Results
- Child Initial Assessment
- Community Functioning Evaluation
- Dangerous Behavior Screening
- Independent living skills scale (ILSS) 9-07
- PECFAS
- Psychiatric Referral Worksheet
- Substance Use Assessment - DD (DMH 553)
- Substance Use Parent/CG Questionaire (DMH 552)
- Substance Use Self Evaluation - DD (DMH 554)
- Suicide Assessment
- Trauma Screening

SVCS 6 month update

- CAFAS Results
- Coordination Plan
- PECFAS
- Permanancy Placement Screening
- Psychiatric Referral Worksheet
- Treatment Team

SVCS Annual update

- Annual Assessment Update
- CAFAS Results
- Community Functioning Evaluation
- Coordination Plan
- Dangerous Behavior Screening
- Independent living skills scale (ILSS) 9-07
- PECFAS
- Psychiatric Referral Worksheet
- Service Integration Team (SIT)
- Suicide Assessment
- Trauma Screening
- Treatment Team

Service Entry

- 90801 0-5 Assessment PN - MAT/FSP
- 90802 0-5 Assessment PN - MAT/FSP
- Administrative D/C Summary / Aftercare Plan
- Annual Assessment Update
- CAFAS Results
- Case Consultation
- Change of Diagnosis
- Child Initial Assessment
- Child Initial Assessment Addendum
- Collateral Contact
- Community Functioning Evaluation
- Coordination Plan
- Crisis Intervention
- Dangerous Behavior Screening
- Discharge Summary / Aftercare Plan
- Family Safety/Crisis Plan
- Family Therapy
- Independent living skills scale (ILSS) 9-07
- Individual Rehabilitation
- Individual Therapy
- No Contact (N/C) Note
- Permanancy Placement Screening
- Plan Development
- Provisional Care Plan
- Psychiatric Referral Worksheet
- Service Integration Team (SIT)
- Substance Use Assessment - DD (DMH 553)
- Substance Use Parent/CG Questionaire (DMH 552)
- Substance Use Self Evaluation - DD (DMH 554)
- Suicide Assessment
- Targeted case management
- Trauma Screening
- Treatment Team

SVCS Discharge

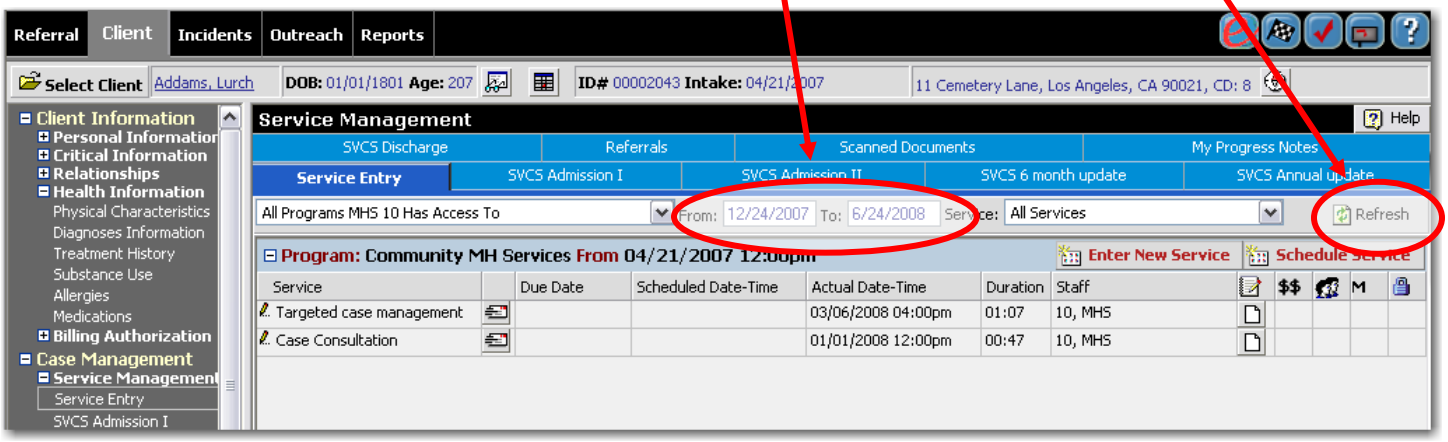
- Administrative CAFAS rev. 9.07
- Administrative D/C Summary / Aftercare Plan
- Administrative PECFAS
- CAFAS Results
- Discharge Summary / Aftercare Plan
- PECFAS

Details of the service entry screen.

Start with “From and To” dates which act like a filter only showing services provided during the time period specified.

The list of services provided for the client within the previous six months will show. To find a service older than six months change the “from and to” dates to list more services.

Then click the refresh button.



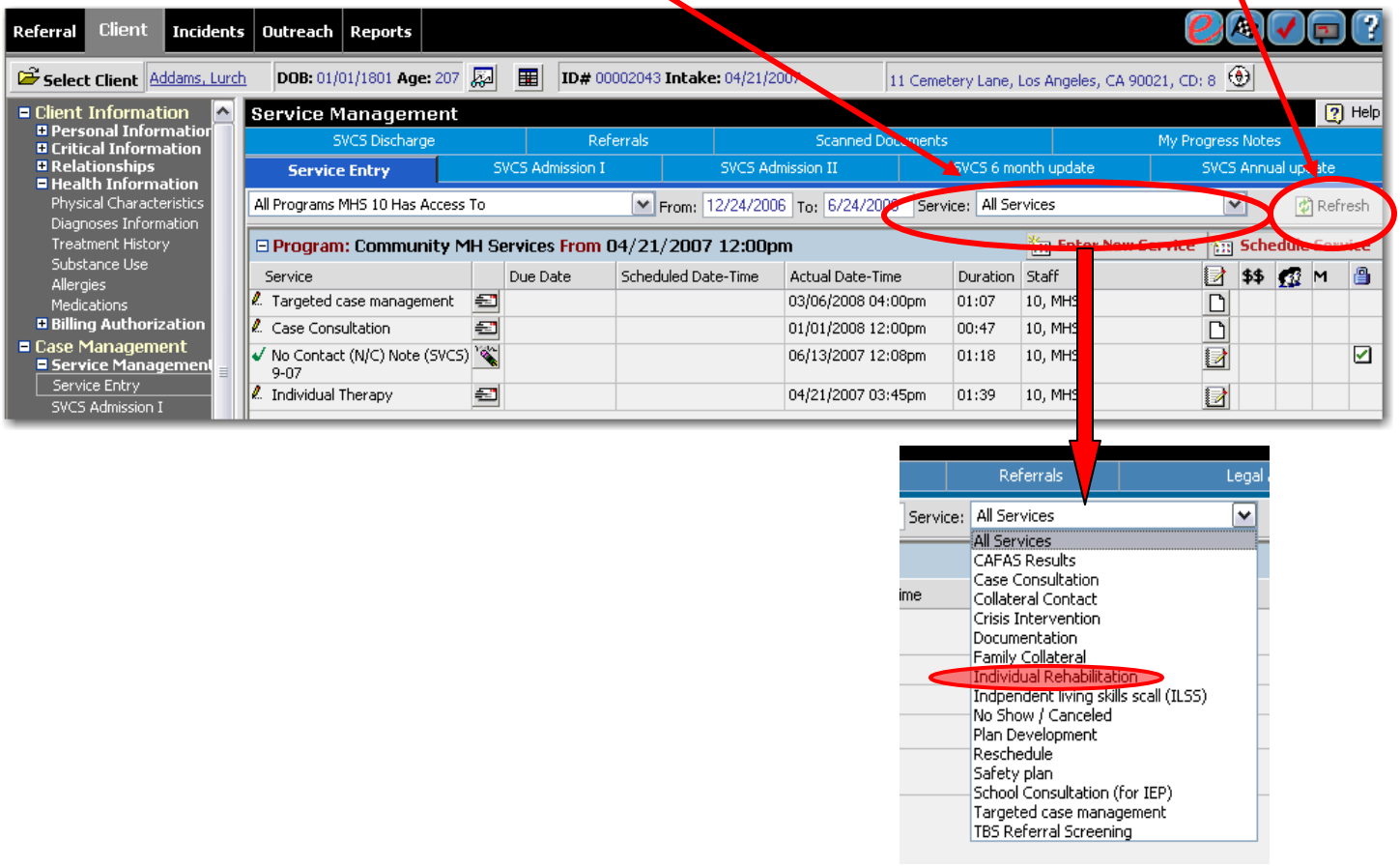
To change the “from or to” date, click in the field and manually change the date by month, day and year. The date needs to be entered numerically.

If you want to view services prior to the last 6-months you need to change the “from” so that it will encompass those dates of service. Example, if a service was provided on 11/17/2006 the “from” date must be on or before that date.

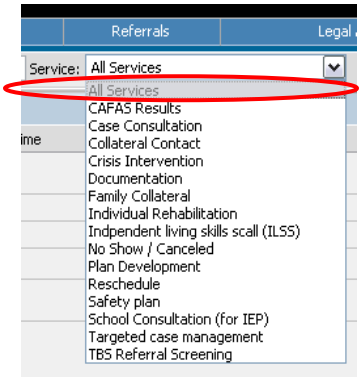
You have the ability to filter the service entry screen by service type. This is accomplished by clicking on the Service drop down menu and then selecting the service desired for review.

If you would like to view specific services click the Service drop down box and select the type of service.

You must click the refresh button.



To show all services again you must select "All Services" from the service filter and click refresh.



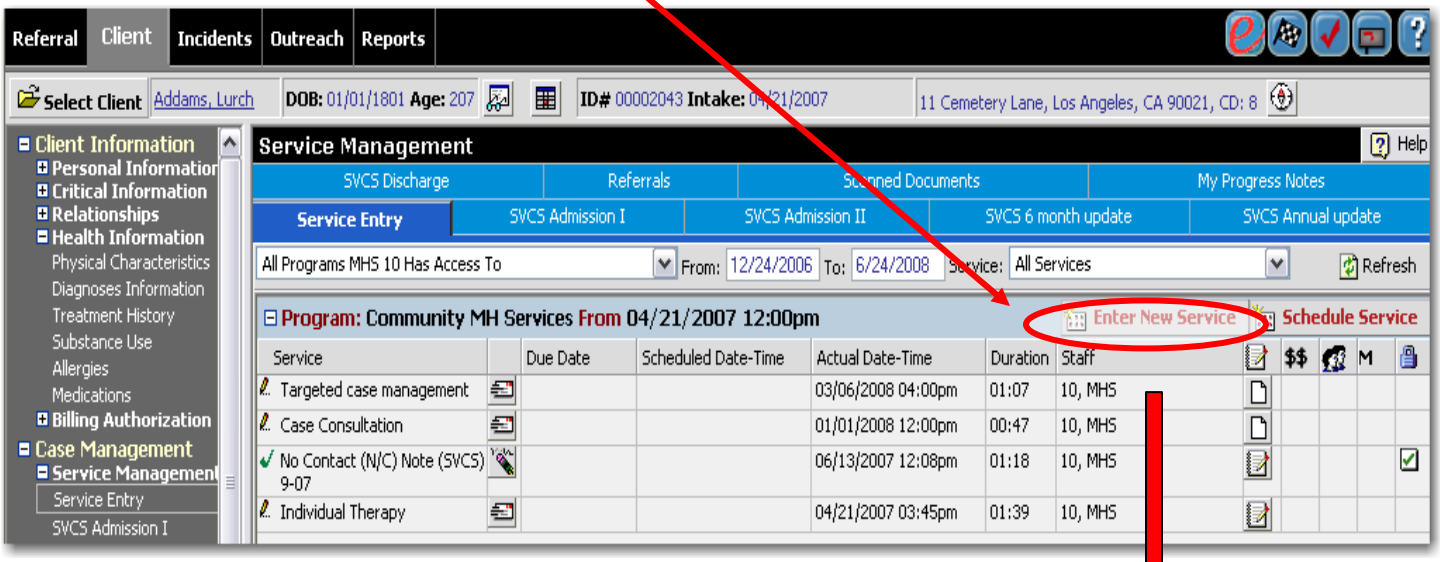
ENTERING A NEW SERVICE

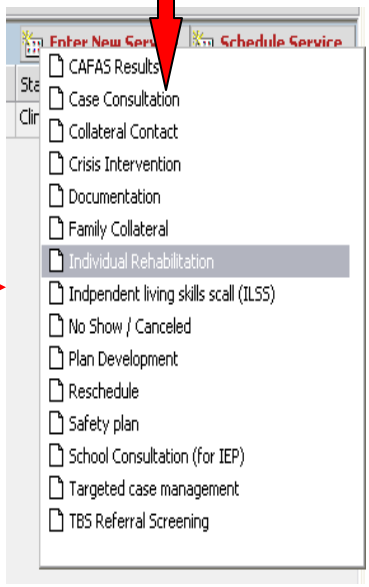
This is where you will document ALL services provided for your client's (except the Treatment Plan which is explained in the Phase II manual).

First, click on Enter New Service

This will open a drop down list of services within the scope of practice of the staff. For this training, each login has the same scope as a Mental Health Specialist II or III.

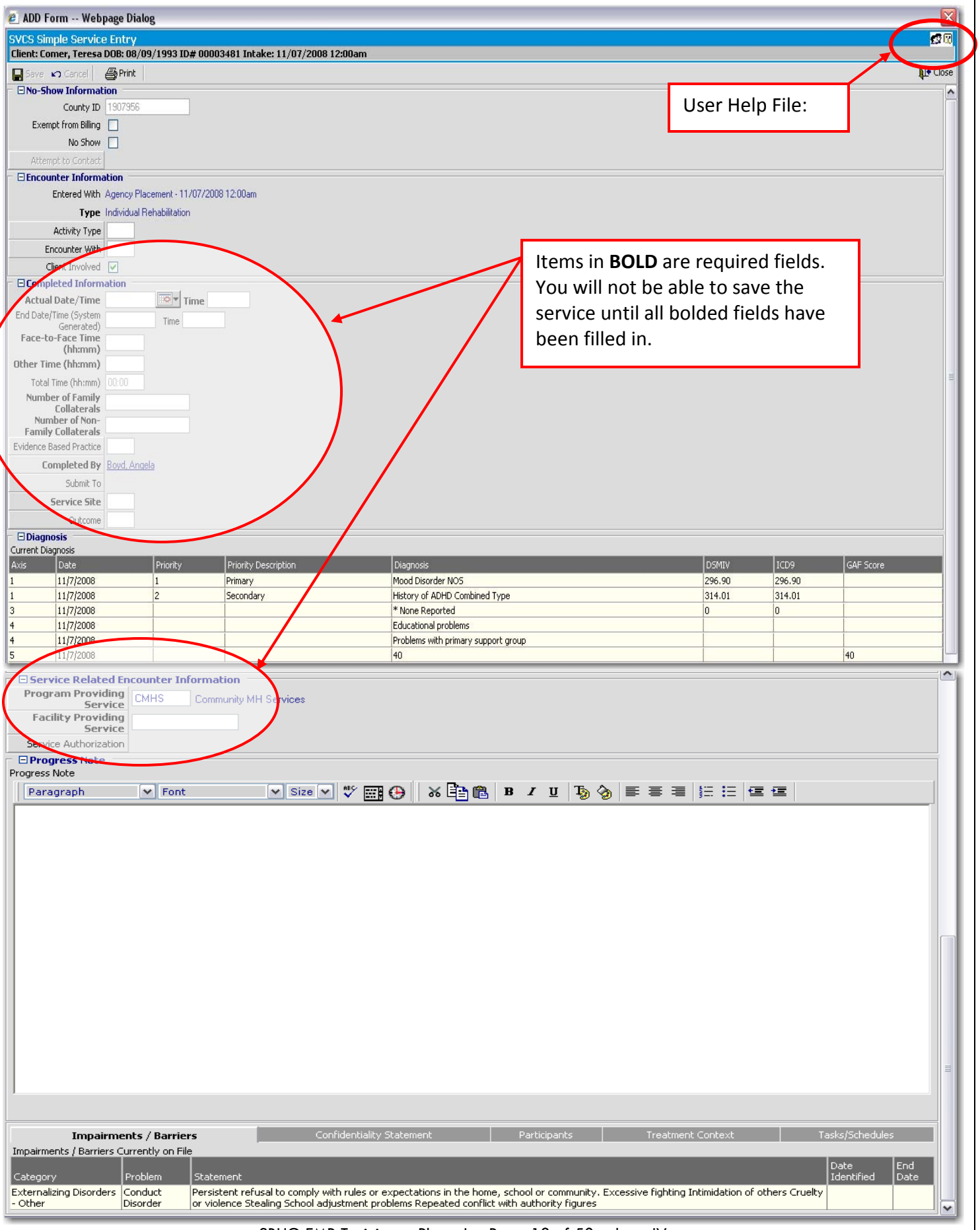
As mentioned on page 14, if you are an MHS I or a Support Counselor your **Enter New Service** drop down list will contain those services within your scope of practice. However all staff no matter their title will be able to view every service that has been entered by everyone working with the client.





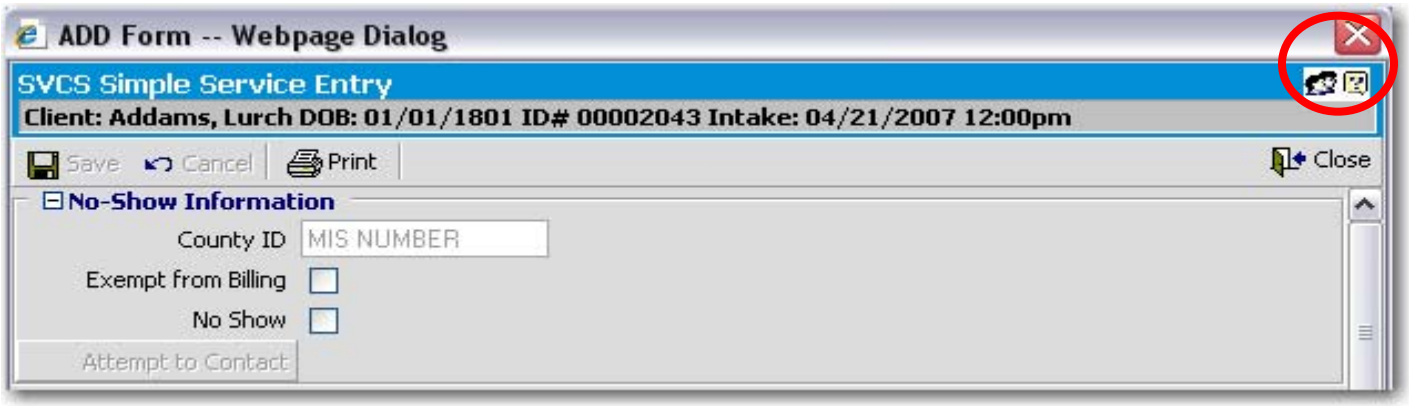
Next Select

A Service Entry form will open where the service and billing information will be entered.


ADD Form -- Webpage Dialog
SVCS Simple Service Entry
Client: Comer, Teresa DOB: 08/09/1993 ID# 00003481 Intake: 11/07/2008 12:00am
Save
Cancel
Print
Close
User Help File:
No-Show Information
County ID 1907956
Exempt from Billing
No Show
Attempt to Contact
Encounter Information
Entered With Agency Placement - 11/07/2008 12:00am
Type Individual Rehabilitation
Activity Type
Encounter With
Client Involved
Completed Information
Actual Date/Time
Time
End Date/Time (System Generated)
Face-to-Face Time (hh:mm)
Other Time (hh:mm)
Total Time (hh:mm) 00:00
Number of Family Collaterals
Number of Non-Family Collaterals
Evidence Based Practice
Completed By Boyd, Angela
Submit To
Service Site
Outcome
Items in BOLD are required fields. You will not be able to save the service until all bolded fields have been filled in.
Diagnosis
Current Diagnosis
Axis | Date | Priority | Priority Description | Diagnosis | DSMIV | ICD9 | GAF Score
1 | 11/7/2008 | 1 | Primary | Mood Disorder NOS | 296.90 | 296.90
1 | 11/7/2008 | 2 | Secondary | History of ADHD Combined Type | 314.01 | 314.01
3 | 11/7/2008 | | | * None Reported | 0 | 0
4 | 11/7/2008 | | | Educational problems
4 | 11/7/2008 | | | Problems with primary support group
5 | 11/7/2008 | | | 40 | | | 40
Service Related Encounter Information
Program Providing Service CMHS Community MH Services
Facility Providing Service
Service Authorization
Progress Note
Progress Note
Paragraph
Font
Size
Impairments / Barriers
Confidentiality Statement
Participants
Treatment Context
Tasks/Schedules
Impairments / Barriers Currently on File
Category | Problem | Statement | Date Identified | End Date
Externalizing Disorders - Other | Conduct Disorder | Persistent refusal to comply with rules or expectations in the home, school or community. Excessive fighting Intimidation of others Cruelty or violence Stealing School adjustment problems Repeated conflict with authority figures

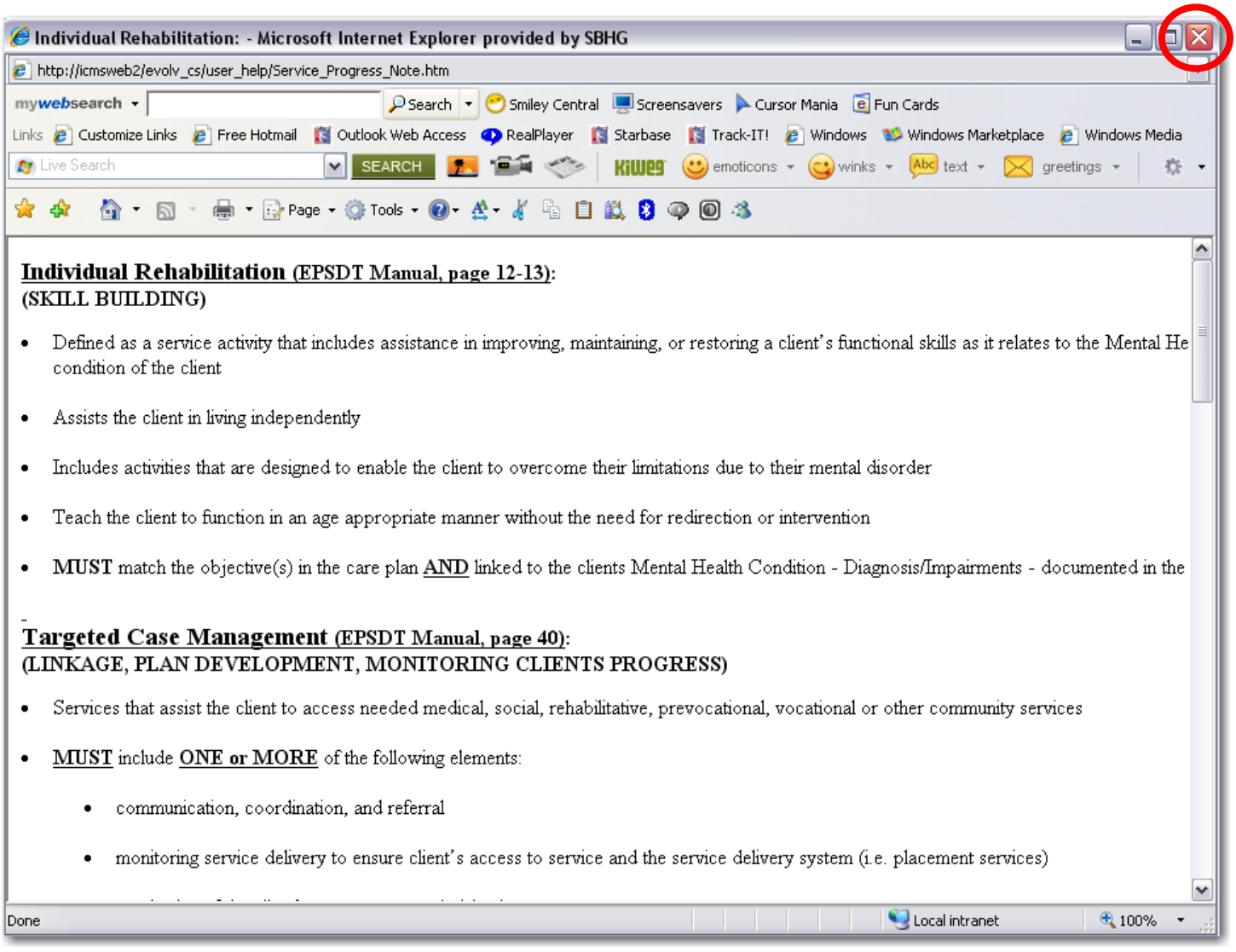
A Closer Look:

User Help File is an EPSDT service glossary that includes definitions and key elements of the various types of services used for writing progress notes.

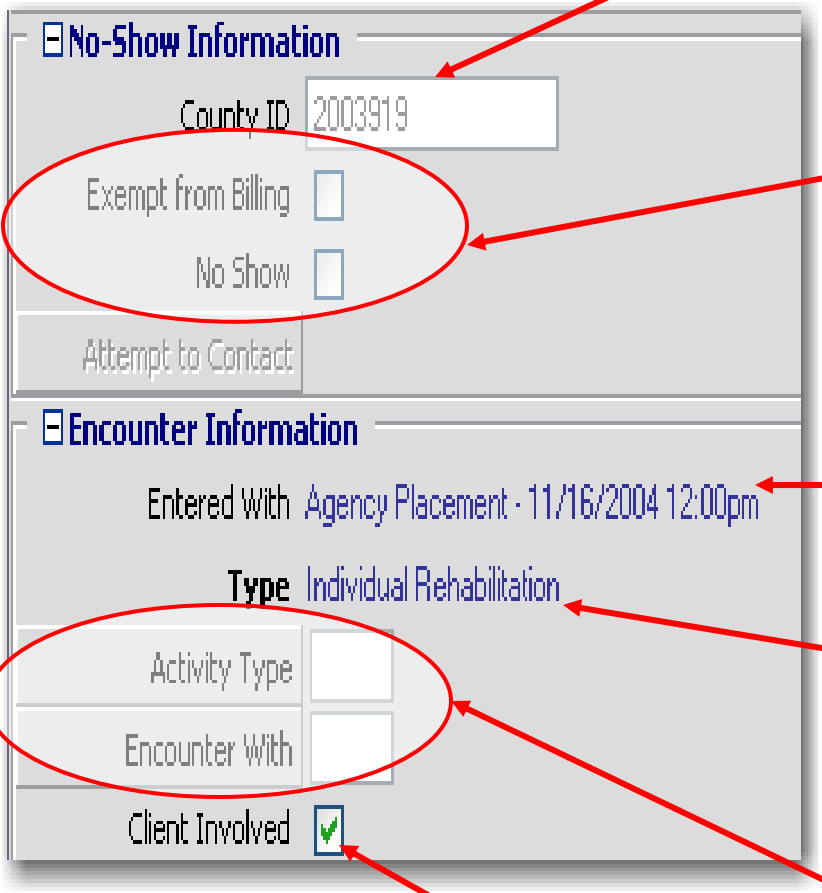


Click on the User Help File button

A separate internet explorer window will open. **To close the window click on the red button**.


Individual Rehabilitation: - Microsoft Internet Explorer provided by SBHG
http://icmsweb2/evolv_cs/user_help/Service_Progress_Note.htm
Individual Rehabilitation (EPSDT Manual, page 12-13):
(SKILL BUILDING)
Defined as a service activity that includes assistance in improving, maintaining, or restoring a client's functional skills as it relates to the Mental He condition of the client
Assists the client in living independently
Includes activities that are designed to enable the client to overcome their limitations due to their mental disorder
Teach the client to function in an age appropriate manner without the need for redirection or intervention
MUST match the objective(s) in the care plan AND linked to the clients Mental Health Condition - Diagnosis/Impairments - documented in the
Targeted Case Management (EPSDT Manual, page 40):
(LINKAGE, PLAN DEVELOPMENT, MONITORING CLIENTS PROGRESS)
Services that assist the client to access needed medical, social, rehabilitative, prevocational, vocational or other community services
MUST include ONE or MORE of the following elements:
communication, coordination, and referral
monitoring service delivery to ensure client's access to service and the service delivery system (i.e. placement services)
Done
Local intranet
100%

Details of the Service Entry form.



County ID: all clients receiving Mental Health Services are given an identification number by the County.

This field is pre-populated and you cannot enter or change the number.

Exempt from Billing and No Show: DO NOT click in either box unless instructed by your supervisor and/or the Finance Department.

BEWARE if either box is checked the service will not be billed.

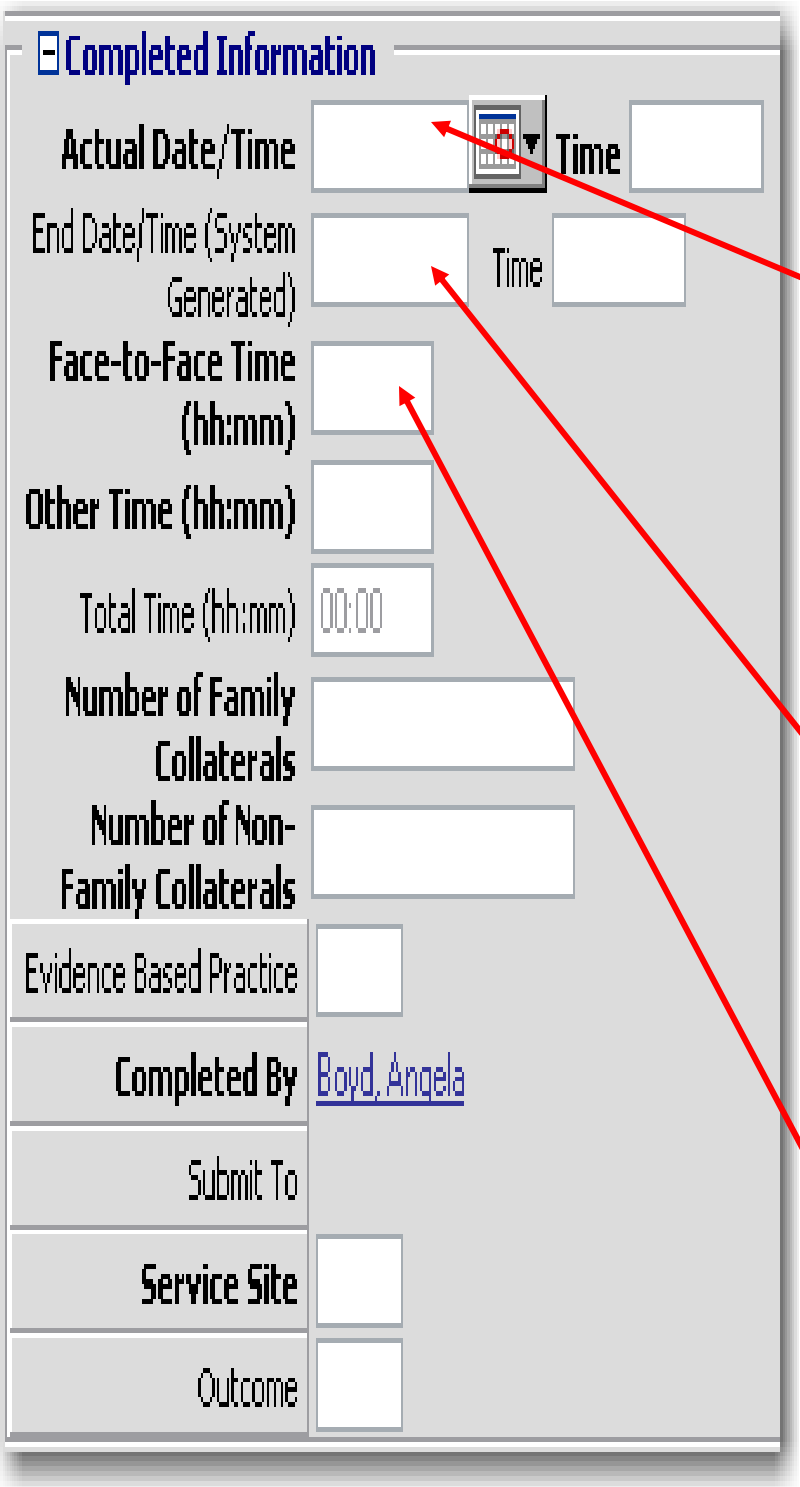
Entered With: identifies the First Date of Service (FDOS). Pre-populated and cannot be modified.

Type: based on your service selection from the drop down list the "type" of service is auto populated.

Activity Type and Encounter With: are not required fields, do not enter any data.

Client Involved: indicates client's involvement in the service.
The system checks this field by default. You must un-check this field if client is not involved in the service.

A closer look at the required fields.

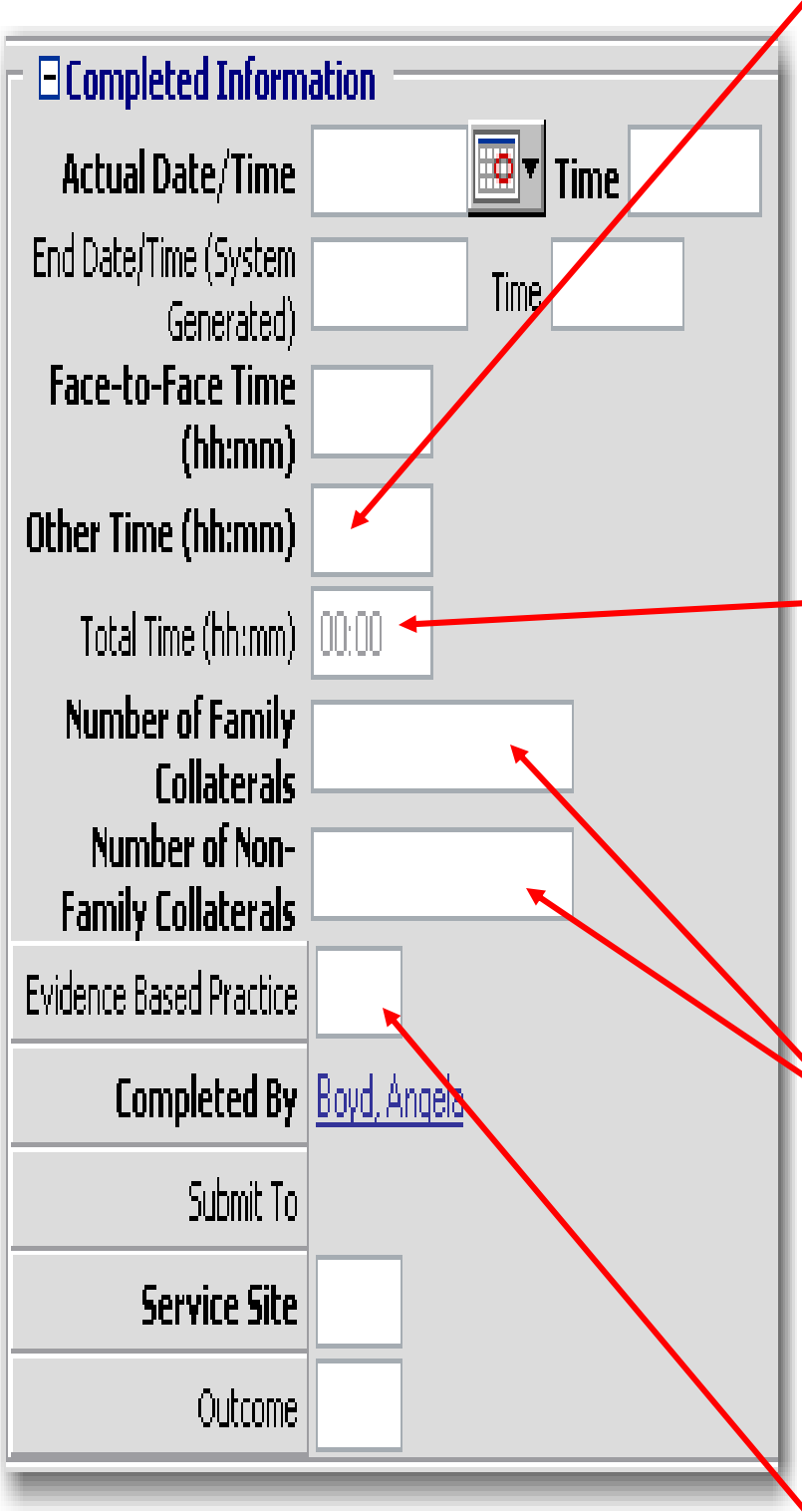


Actual Date/Time is the date and time you provided the service.
Date can entered numerically either by hand (can use / or -) or by clicking on the calendar
Time is actual time service started. Time is entered numerically (i.e. 1:42 pm or 9:34 am).
NOTE: the EMR will not allow a future Date OR Time to be entered.

End Date/Time is automatically generated by the system when you save the service.
NOTE: the End Date/Time field is automatic and will not allow you to enter any information.

Face-to-Face Time: In order to claim Face-to-Face time the client MUST be present.
NOTE: Enter time in minutes. The system automatically changes it to hours and minutes (ex. 63 minutes would appear as 1:03).

Continued look at the required fields.



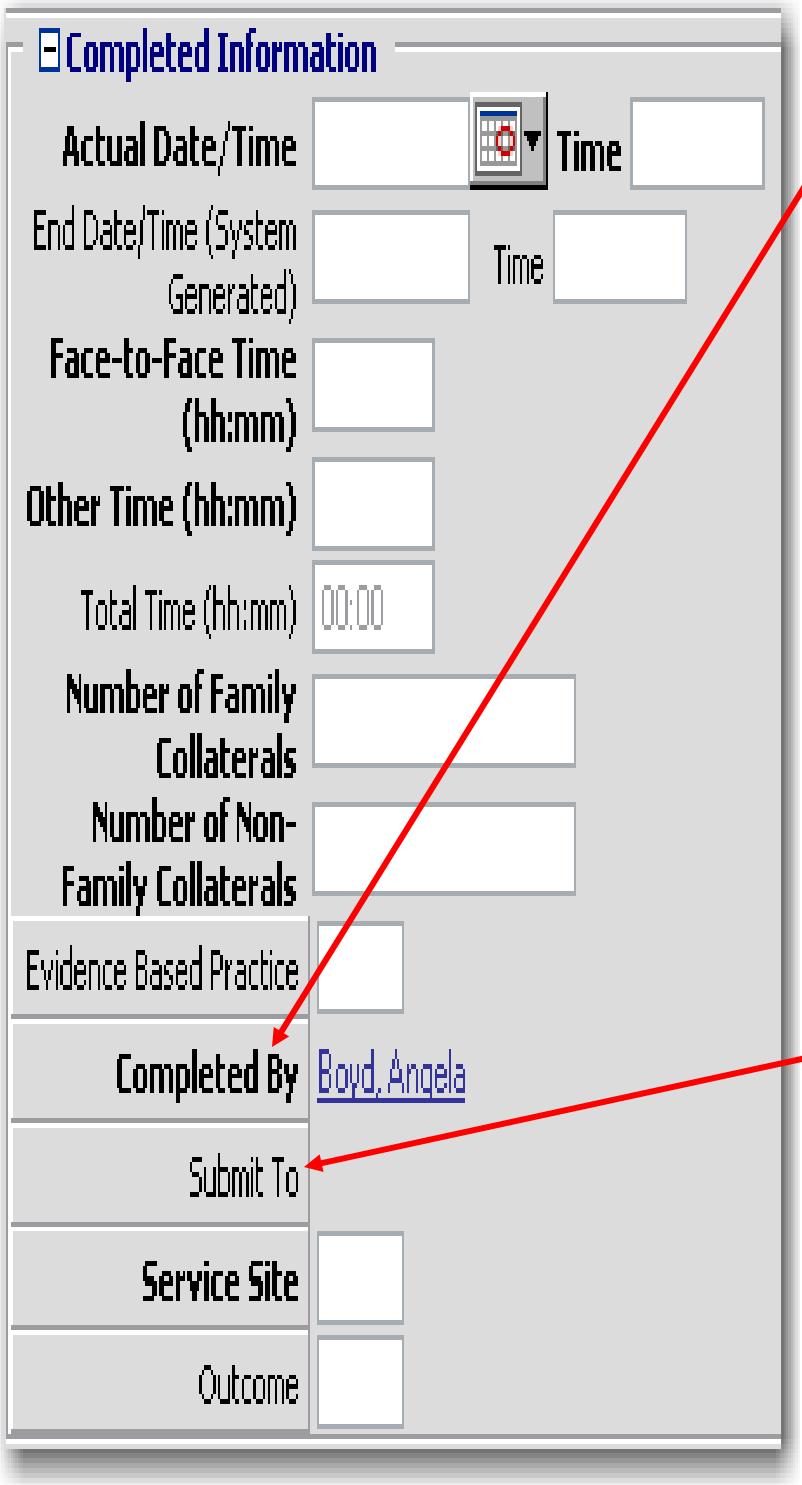
Other Time is Service + Documentation + Travel. Service is defined any time the client is NOT present for the service. Examples: Collateral, Targeted Case Management, Case Consultation, services etc. provided WITHOUT the client present.
NOTE: Enter time in minutes. The system automatically changes it to hours and minutes (ex. 63 minutes would appear as 1:03).

Total Time: the system Auto Adds Face-to-Face and Other Time and populates this field automatically with the total when the service is saved. You can not change this time.

Number of Family and Non-Family Collaterals: you must indicate the number of Family and Non-Family collaterals present during your session. Client is not counted in the number of Family Collateral.
Staff providing service is not part of any count.
Examples of Non-Family Collaterals would be any person that the client, family or staff considers an integral part of the client's treatment (i.e. CSW, PO, etc).
If there are no Family or Non-Family Collaterals present enter 0 in both fields.

Evidence Based Practice: not a required field, at this time you do not need to enter any data.

Continued look at the required fields.



Completed By:
When you log into the EMR with your user name and password and enter a service it will auto populate this field with your name. DO NOT change this field.

BEWARE: If you share your user name and password with somebody your name will show here as if you documented the service. You are then responsible for any information entered.

DO NOT share your user name and password; it's a violation of HIPAA and against company policy.

Submit To: this is where you identify who this service will be submitted to for approval.

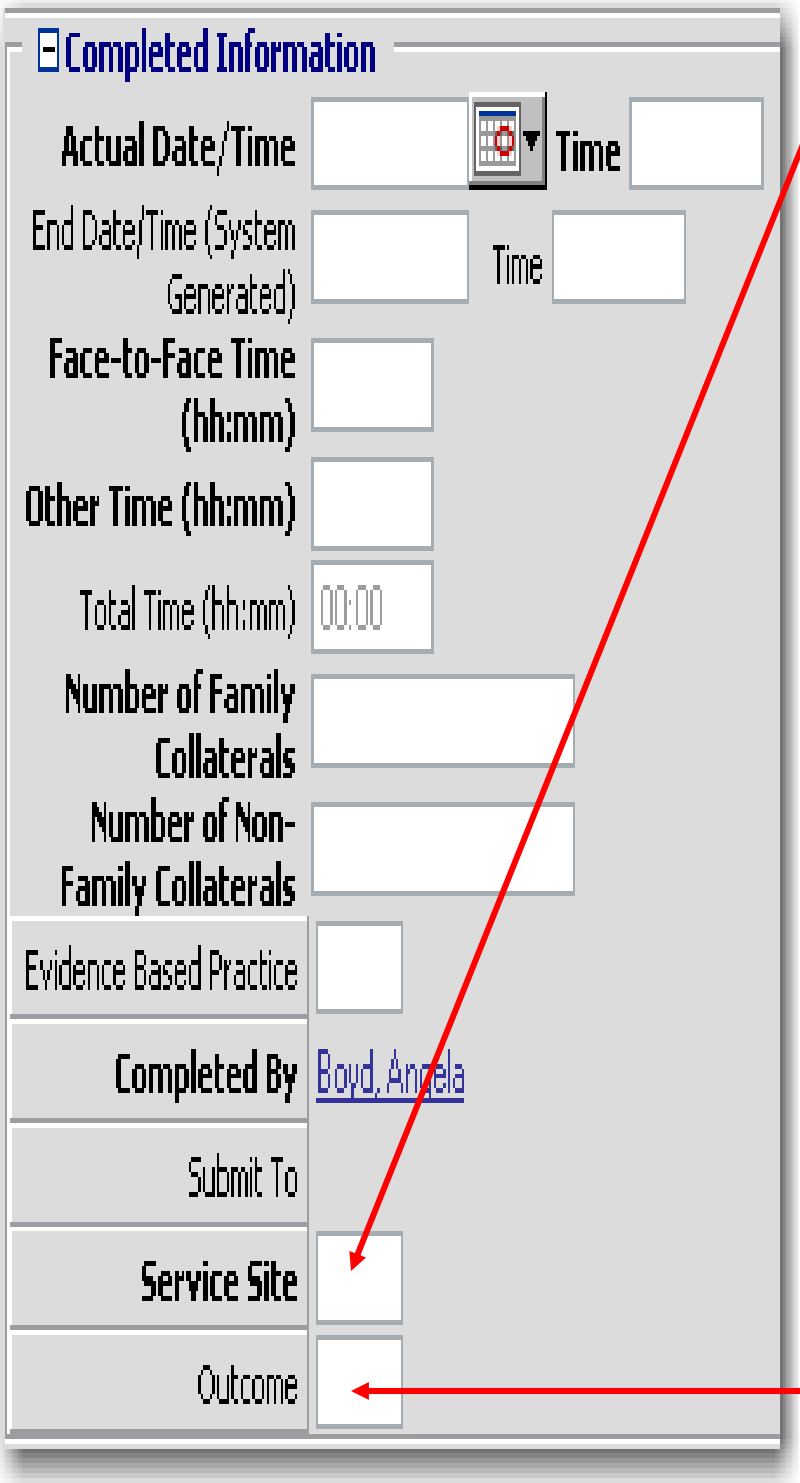
If submitting this service to your supervisor, leave this field alone, it will automatically submit to your supervisor by default.

If you need to submit this service to someone other than your supervisor,

1. click on the Submit To button

   a drop down list of names will appear
2. type in the last name or first name of the identified person
3. click the search button, the persons name will show
4. click on the persons name

Continued look at the required fields.



Service Site: Indicates the location where you provided the service.
To select the Service Site:

1. Click on the Service Site button,

   A drop down description list will Appear
2. Click on the location

NOTE: Do not select Facility Vehicle or Staff Vehicle as a location. If a service is provided while in your vehicle select Other, Outing Location or Public Setting instead.

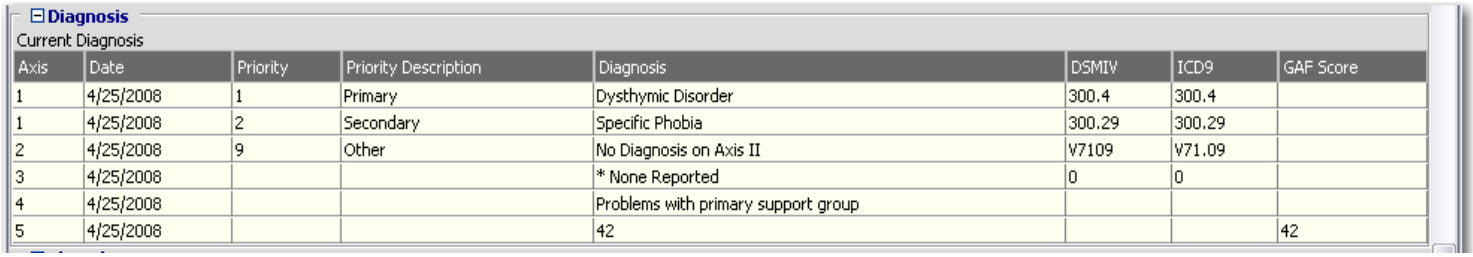
Once you click on the location the short cut number automatically populates the field and the description name appears next to the field.

Outcome: is not a required field, you do not need to enter any data in this field.

Viewing Diagnosis and Impairments/Barriers within the Service Entry form.

This is a VIEW ONLY example of where you would see the Diagnosis and Impairments/Barriers in the Service Entry form.

Changes can NOT be made to these fields. You have the ability to reference this information when writing your progress notes. If the Diagnosis needs to be changed an MHS II or III MUST complete a Change of Diagnosis form and turn it into the Center/TM Intake Coordinator. They will then need to complete the billing information in the EMR by selecting Change of Diagnosis in the Service Entry Screen.

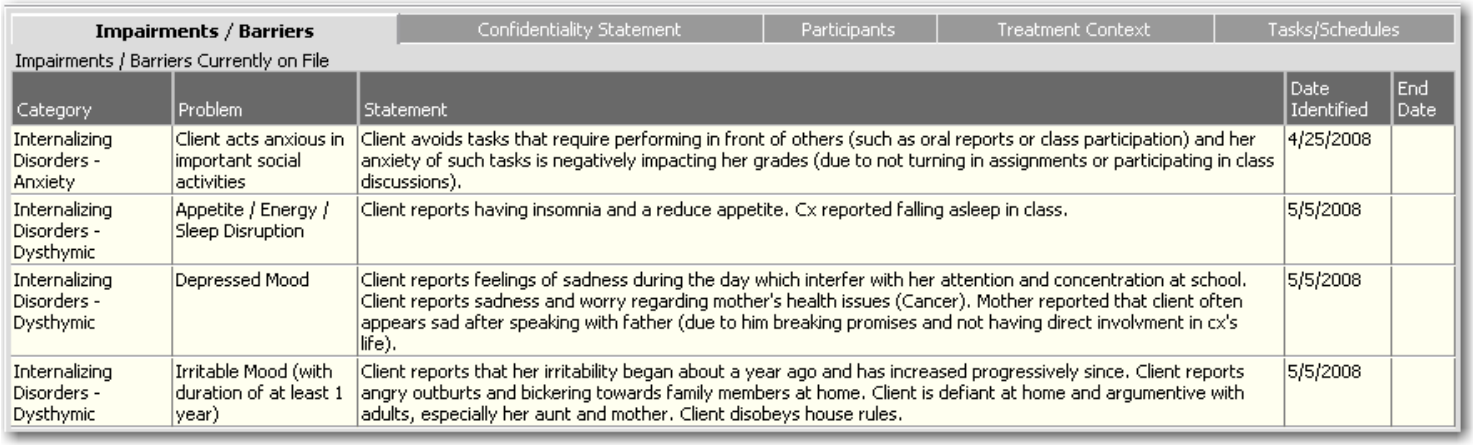


Diagnosis

Current Diagnosis

Axis	Date	Priority	Priority Description	Diagnosis	DSMIV	ICD9	GAF Score
1	4/25/2008	1	Primary	Dysthymic Disorder	300.4	300.4	
1	4/25/2008	2	Secondary	Specific Phobia	300.29	300.29	
2	4/25/2008	9	Other	No Diagnosis on Axis II	V7109	V71.09	
3	4/25/2008			* None Reported	0	0	
4	4/25/2008			Problems with primary support group			
5	4/25/2008			42			42

Impairments / Barriers can be found beneath the Progress Note section in the Service Entry form.

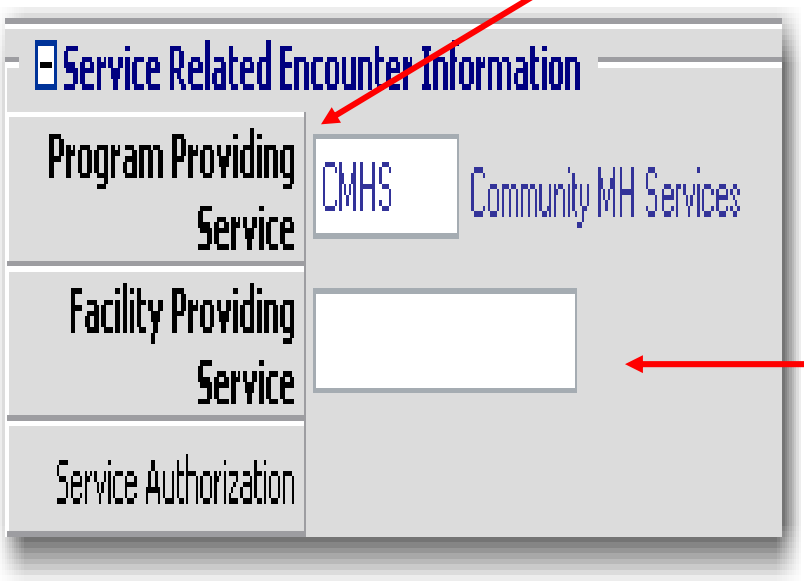


Impairments / Barriers | Confidentiality Statement | Participants | Treatment Context | Tasks/Schedules

Impairments / Barriers Currently on File

Category	Problem	Statement	Date Identified	End Date
Internalizing Disorders - Anxiety	Client acts anxious in important social activities	Client avoids tasks that require performing in front of others (such as oral reports or class participation) and her anxiety of such tasks is negatively impacting her grades (due to not turning in assignments or participating in class discussions).	4/25/2008	
Internalizing Disorders - Dysthymic	Appetite / Energy / Sleep Disruption	Client reports having insomnia and a reduce appetite. Cx reported falling asleep in class.	5/5/2008	
Internalizing Disorders - Dysthymic	Depressed Mood	Client reports feelings of sadness during the day which interfer with her attention and concentration at school. Client reports sadness and worry regarding mother's health issues (Cancer). Mother reported that client often appears sad after speaking with father (due to him breaking promises and not having direct involvment in cx's life).	5/5/2008	
Internalizing Disorders - Dysthymic	Irritable Mood (with duration of at least 1 year)	Client reports that her irritability began about a year ago and has increased progressively since. Client reports angry outburts and bickering towards family members at home. Client is defiant at home and argumentive with adults, especially her aunt and mother. Client disobeys house rules.	5/5/2008	

Continued look at the required fields.



Program Providing Service: Should auto populate to Community MH Services (CMHS). If it does not auto-populate:

1. click the Program Providing Service button

2. a drop down list will open
3. select Community MH Services from the drop down list

Facility Providing Service: You must select the Facility where the service was provided. If the service was provided out in the field then select the facility you are assigned.

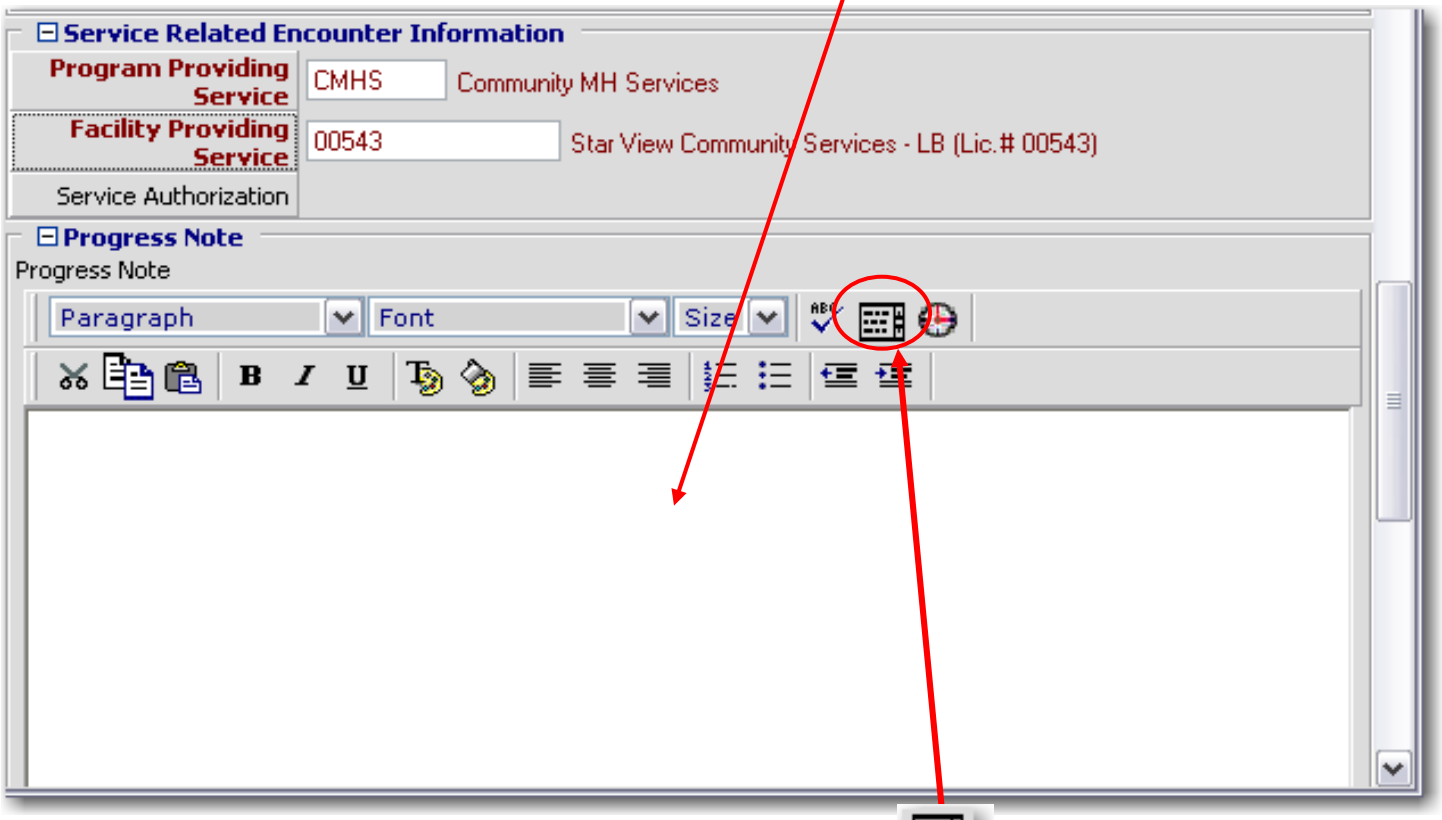
1. click on the Facility Providing Service button

2. a drop down menu will open showing ALL locations where Community MH Services can be provided
3. select the location (HINT, since most of the facilities begin with STARS it would be easier to select the **correct Facility based on the address**)

BE VERY ***careful*** in selecting the correct Facility or the service will be billed incorrectly.

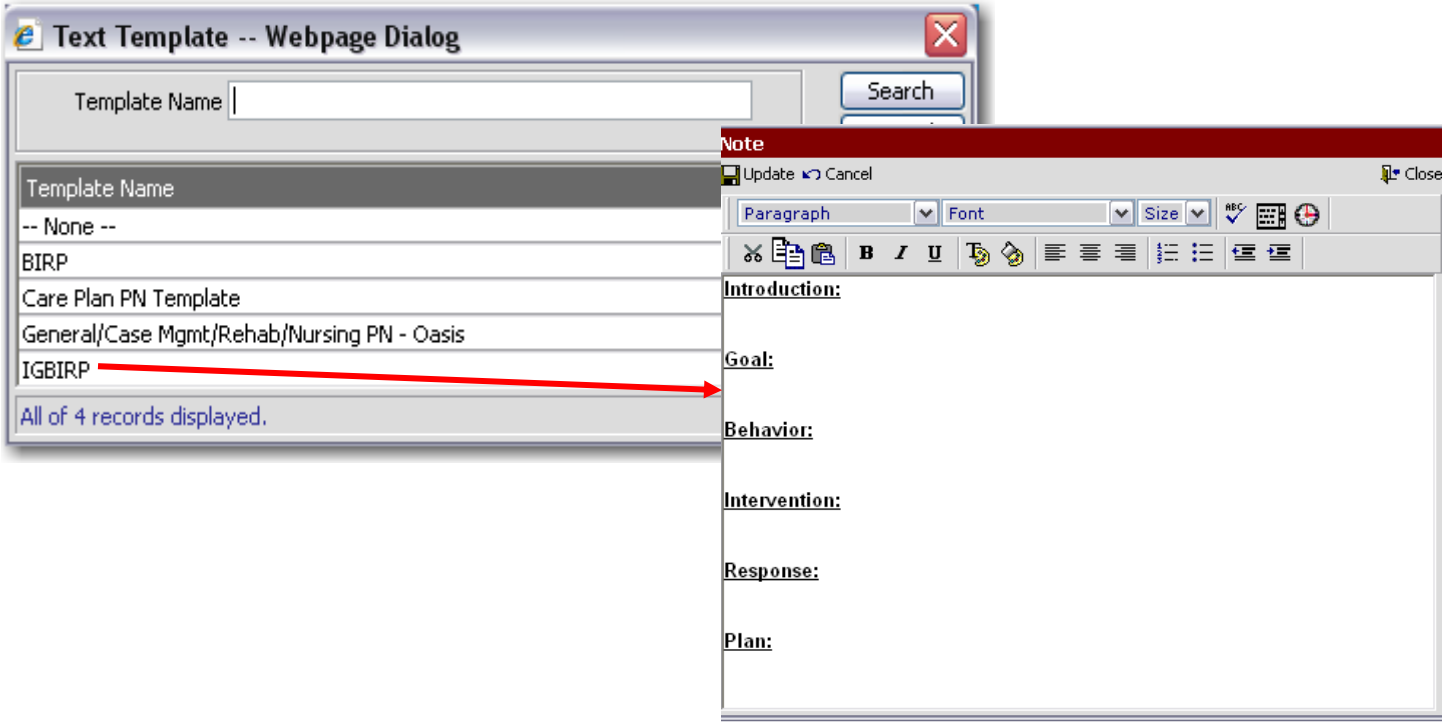
Scroll down to the Progress Note Section just below the Facility Providing Service button.

You are able to type a narrative note by clicking in the progress note area **OR** you are able to select a progress note template that will auto populate.



To select a Progress Note template click on the template icon.

A drop down list of templates will open. Select the desired template. Type in the content of your note under the IGBIRP template headers:



PROGRESS NOTE TEMPLATES

If the client's collateral information and/or Treatment Plan are already in the system it impacts your choice between IGBIRP, BIRP, IBIRP or GBIRP format.

IGBIRP: You use the IGBIRP format when the collateral information and Treatment objectives are NOT entered into the EMR.

BIRP: You use the BIRP format when the collateral information AND objectives in the Treatment Plan have been entered into the EMR.

NOTE: To get collateral information entered into the EMR, staff MUST submit Collateral Information form and submit it to the Center Coordinator at their site or the Wrap MH Intake Coordinator.

IBIRP: You use IBIRP format if the collateral information is NOT in the EMR but the objectives are entered into the EMR.

GBIRP: You use GBIRP format if the collateral information IS in the EMR but the objectives are not entered into the EMR.

The following services require a progress note:

- Crisis Intervention
- Family Therapy
- Individual Therapy
- Individual Rehabilitation
- N/C (No Contact) Note
- TBS Progress Note
- Targeted Case Management
- Case Consultation
- Collateral
- Care Plan
- Change of Diagnosis
- Dangerous Behavior Safety Plan
- Family Safety Crisis Plan
- Suicide Safety Plan
- TBS Monthly Review

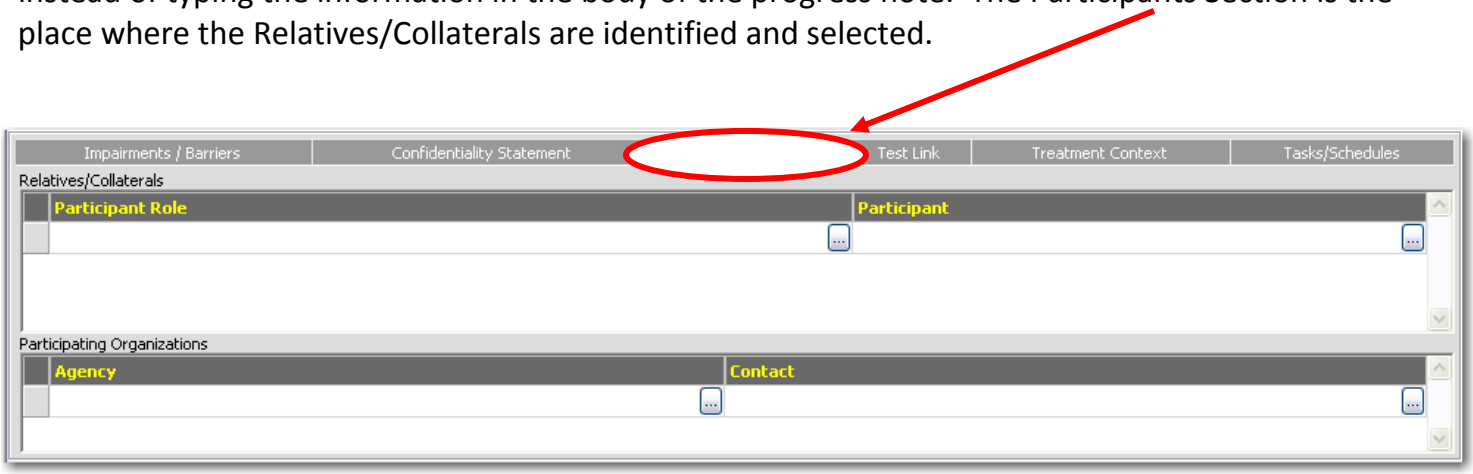
You WILL NOT be able to submit the above services without a progress note.

For services not needing a progress note refer to the Service Grid located in the back of this manual starting on page 37.

COLLATERALS/PARTICIPANTS PRESENTS

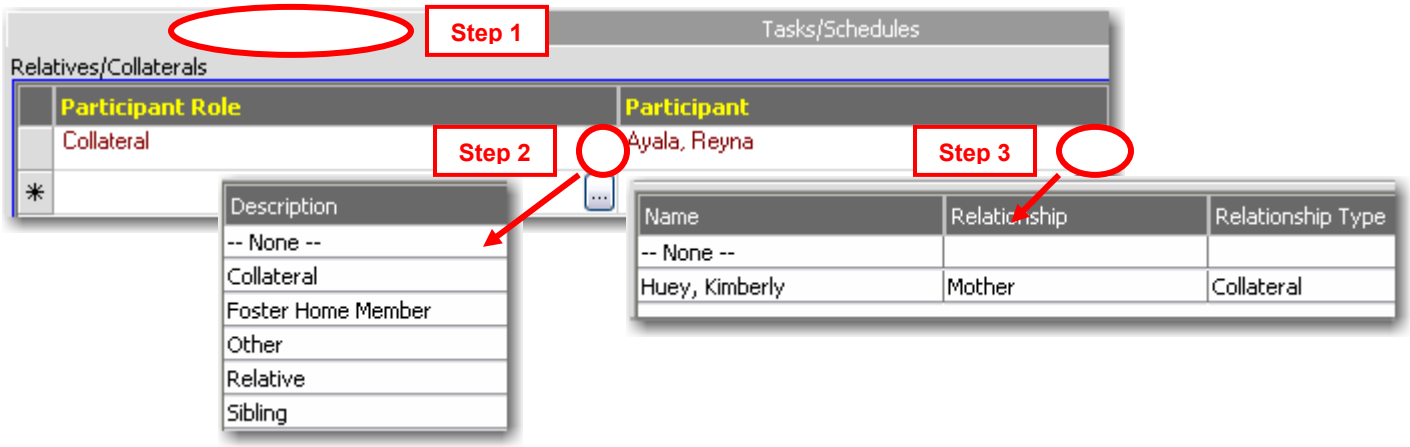
Now that you are done with the body of your note you MUST identify who was present during the session.

If you indicate there was Family and/or Non-Family Collateral Present during the session you MUST identify who they are. The EMR allows you to select collateral information from a drop down box instead of typing the information in the body of the progress note. The Participants Section is the place where the Relatives/Collaterals are identified and selected.



When selecting a participant(s)/collateral(s) utilize the following steps:

1. At the bottom of the service click the Participants tab
2. Click the ellipses under Participants Role and select the description
3. Click the ellipses under Participant and select the name of the participant

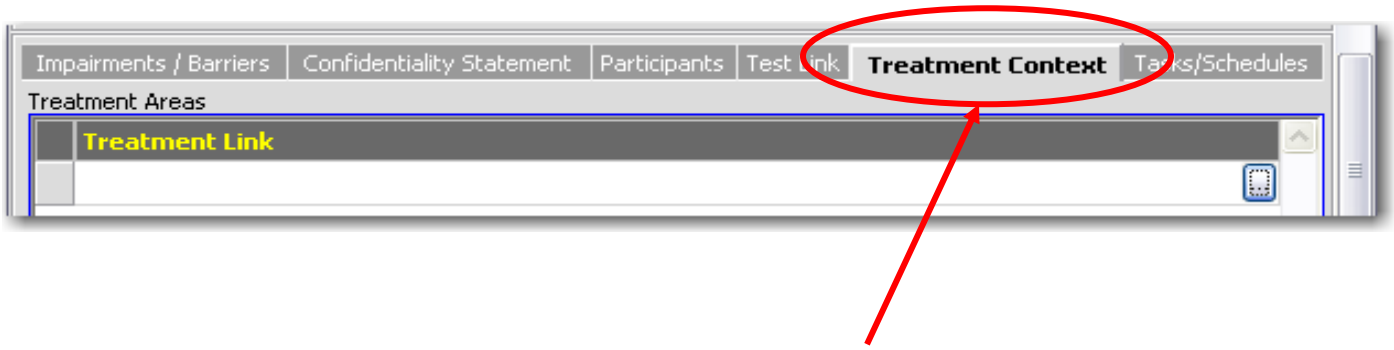


VERY IMPORTANT: in order to select a collateral from within the Participants dropdown box the collaterals MUST first be entered into the EMR. Contact your Center Coordinator to have the collaterals entered into the EMR.

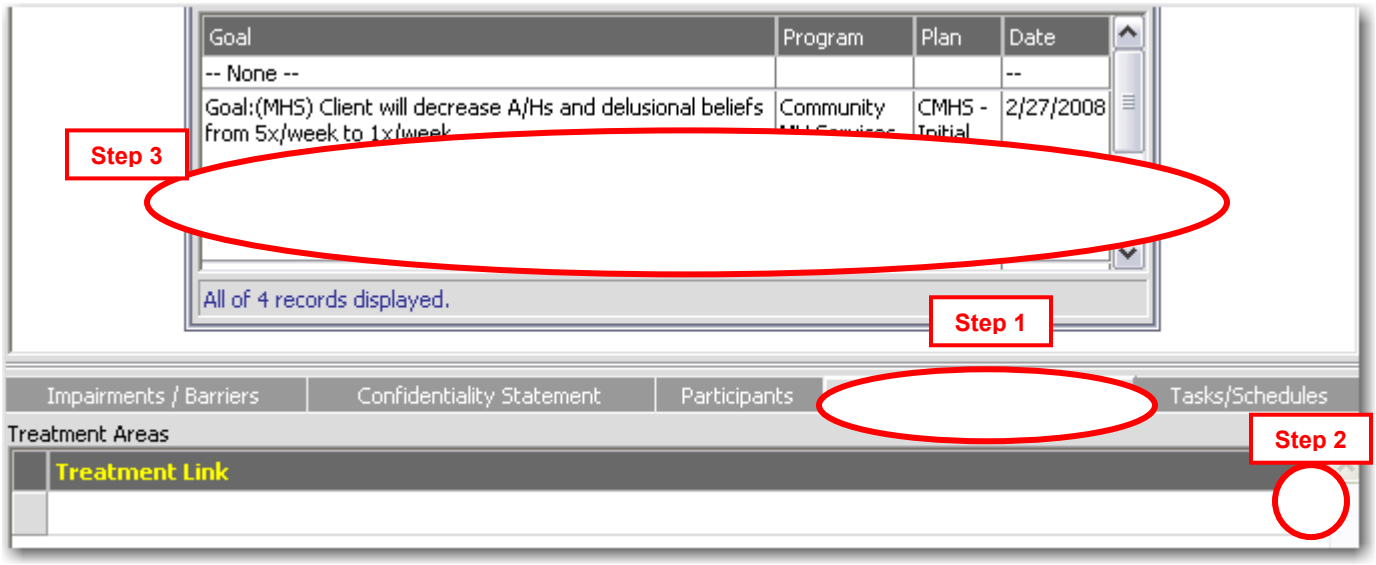
IF the collateral information is not entered into the EMR yet, document in the body of the note the collateral present during the session, complete a Collateral Information sheet (attached) and give it to your Center Coordinator.

SELECTING OBJECTIVE ADDRESSED / TREATMENT CONTEXT

Now that the participants have been selected you need to select which objective was being addressed during the session. The EMR allows you to select an objective from a drop down box instead of typing the information in the body of the progress note.



1. At the bottom of the service click the Treatment Context tab
2. Click the ellipses within the Treatment Context tab
3. Click the current objective/goal on file you worked on during the session. The result will look like this:



4. The result will look like this:

You can select an objective link for the following services:

- Crisis Intervention
- Family Therapy
- Individual Therapy
- Individual Rehabilitation
- N/C (No Contact) Note
- TBS Progress Note
- Targeted Case Management
- Case Consultation
- Collateral

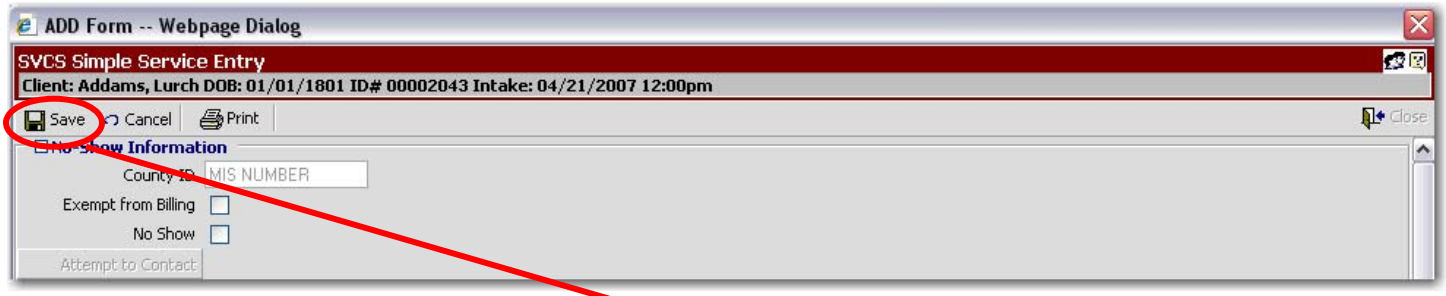
NOTE: If the Treatment Plan is NOT completed in the EMR, you will NOT be able to select the objective/goal within the Treatment Context. If this is the case you will NEED to continue to type in the objective/goal within the body of the progress note until the Treatment Plan is completed.

IF new behavior(s) occur during the session you will need to document them under the B (behavior) section in the body of the progress note. Additionally, you must indicate an objective/goal will be developed to address the new behavior(s).

IF Crisis Intervention is provided and there is no objective on file, document the behavior(s) and intervention(s) in the body of the progress note. Additionally, you must indicate if an objective/goal will be developed to address the behavior.

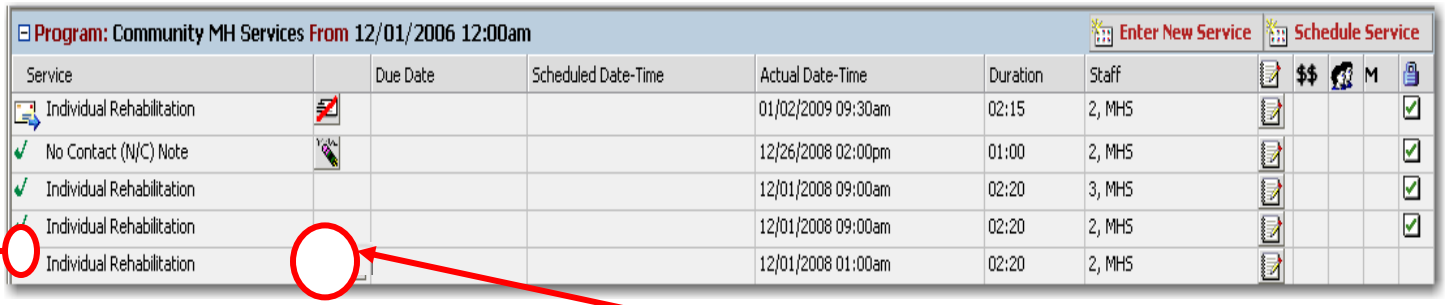
SAVING A SERVICE

You are now ready to Save this service.



To save the this service click on the save button

When you save you will be brought back to the Service Entry Screen under the Client Module. The saved service will now show in draft format in the Service Entry Screen. You can modify this service at any time while in draft format by simply clicking on the service.



Depending upon the service provided one of two icons will appear to the right of the service entered, a submit button or electronic signature button (see next page for more explanation).

The service you selected (Individual Rehabilitation) requires supervisor's approval so you must click the envelope to the right of the service.

SUBMITTING A SERVICE VS. ELECTRONICALLY SIGNING A SERVICE

To forward a service for approval simply click the submit button located to the right of the service entered. **Your electronic signature will be attached to this service upon submission to your supervisor.**

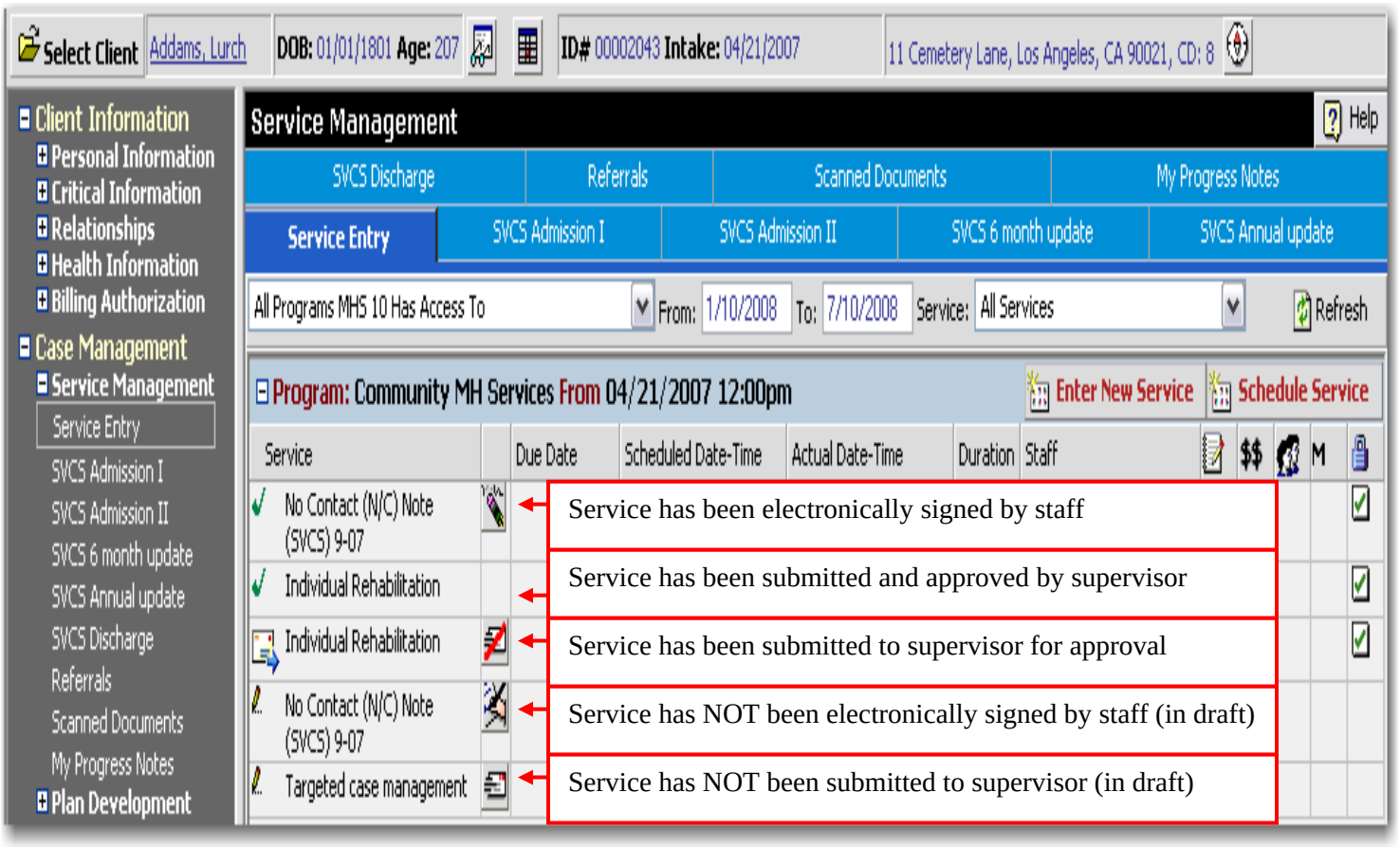
To electronically sign a service that does not require your supervisors approval, simply click the pencil icon located to the right of the service entered.

For the list of forms/services that require submitting to your supervisor vs. an electronic signature from you refer to the Service Grid beginning on page 37.

NOTE: if a service is left in draft form (not submitted to your supervisor for approval OR not electronically signed) it will NOT be billed. All Services must either be submitted and approved by your supervisor or electronically signed by you to be billed. Leaving a service in draft form is the equivalent of having an un-signed progress note in the client's chart which is a recoupment risk.

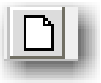
***Creating "skeleton services" (saving a service where only the required fields are complete) and leaving them in draft for the purpose of increasing your productivity is considered FRAUD. If you create a service with the intention of returning at another time to finish the service, keep in mind that per DMH policy ALL services are to be documented and signed (submitted) within 24 business hours of the date of the service. Creating services and leaving them in draft is against DMH policy.

So let's review the icons that will appear next to the services entered.



See Icon Table on next page for more detailed information on what each icon indicates.

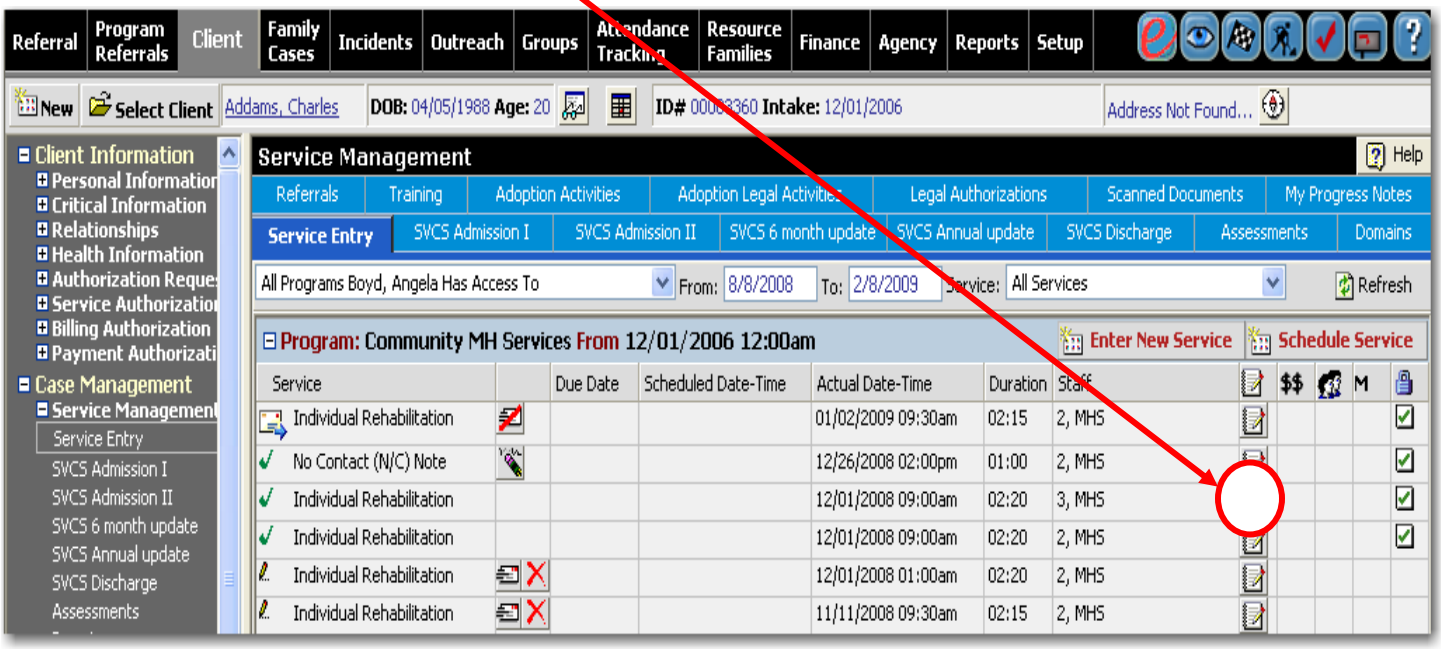
Icon Table

	The pencil icon indicates the service is saved in draft format and has not been submitted for approval. You able to modify this service while draft format. Do not leave services in draft format for more than a week. When services remain in draft format they do not get billed.
	Use the Submit Button to forward services to your supervisor or designee for approval. **Your electronic signature will be attached to this service upon submission to your supervisor.**
	Click this button to apply your **Electronic Signature** for those services that do not require supervisor approval. Refer to the Service Grid for a list of services.
	The envelope with an arrow indicates the service has been submitted to your supervisor for approval. Once the service has been submitted it is no longer modifiable. **If you need to edit the service and/or note for any reason you will need to contact your supervisor and ask them to "un-submit" the service. You will then be able to make the desired changes and then re-submit back to your supervisor.**
	This icon will take the place of the Electronic Signature icon. Explain to the participants that this symbol does not impact them.
	Indicates the services has been approved by your supervisor
	Explain to the participants that the symbol of an envelope with a red line does not impact them.
	Indicates a progress note has been written in this service.
	Indicates a progress note has NOT been written for this service. For services that require a progress note you will not be able to submit them when this icon is showing.
	This icon indicates that your Electronic Signature has been applied.
	Service has pulled into a batch. If there is a green check mark under this column the service has been pulled into a batch and has been or is ready to be billed.
	Participants were involved in service. If there is a green check mark under this column that indicates participants were selected from drop down box within the service.
	Materials were used during service (not common). If a green check mark is under this column it indicates materials were used during the service.
	Electronic Signature was applied by original author of the service. When there is a green check mark under this column that indicates the electronic signature of the original author was applied to this service.

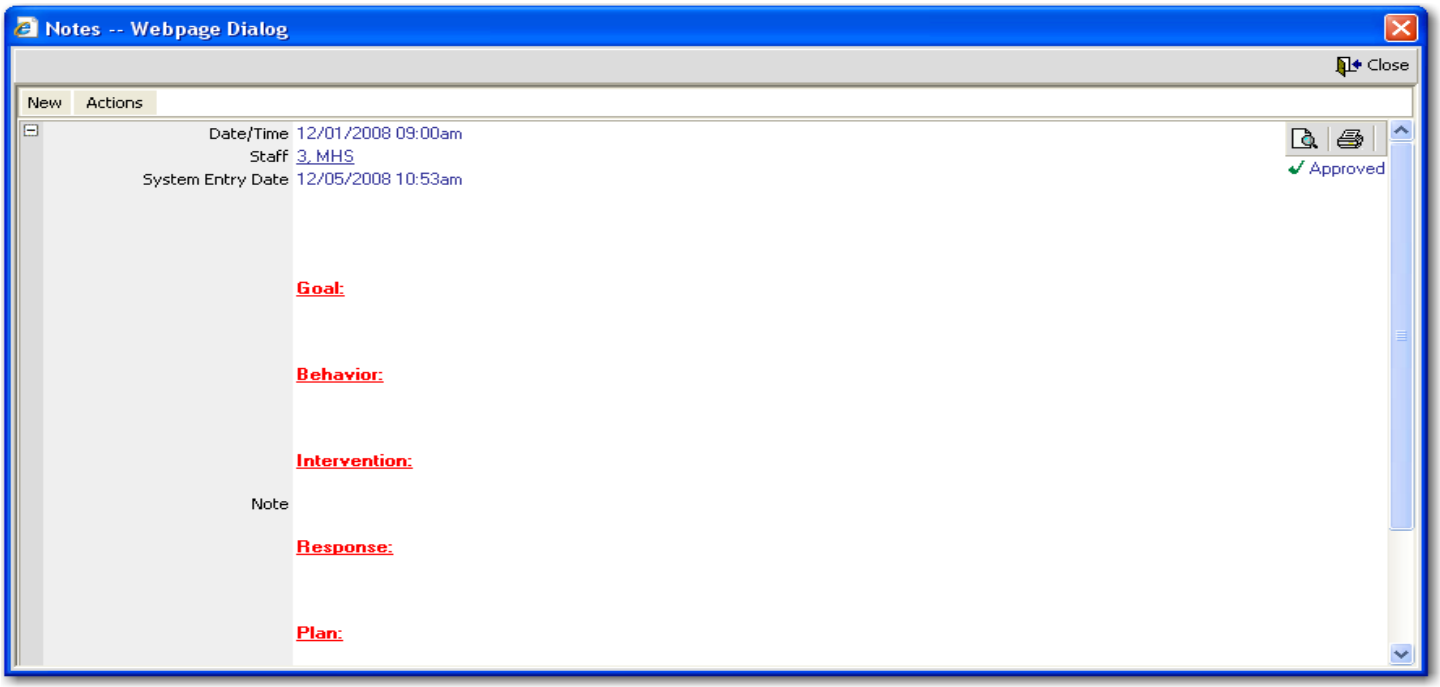
ADDING AN ADDENDUM TO A PROGRESS NOTE

If, for whatever reason, you or your supervisor feels the progress note needs additional information in the body of the note, instead of your supervisor un-approving / un-approving the note back to you, you are able to add an addendum to the body of the note while the Progress Note is in Submitted or Approved status. If the Progress Note is in draft you are able to edit the content of the Progress Note from within the Service.

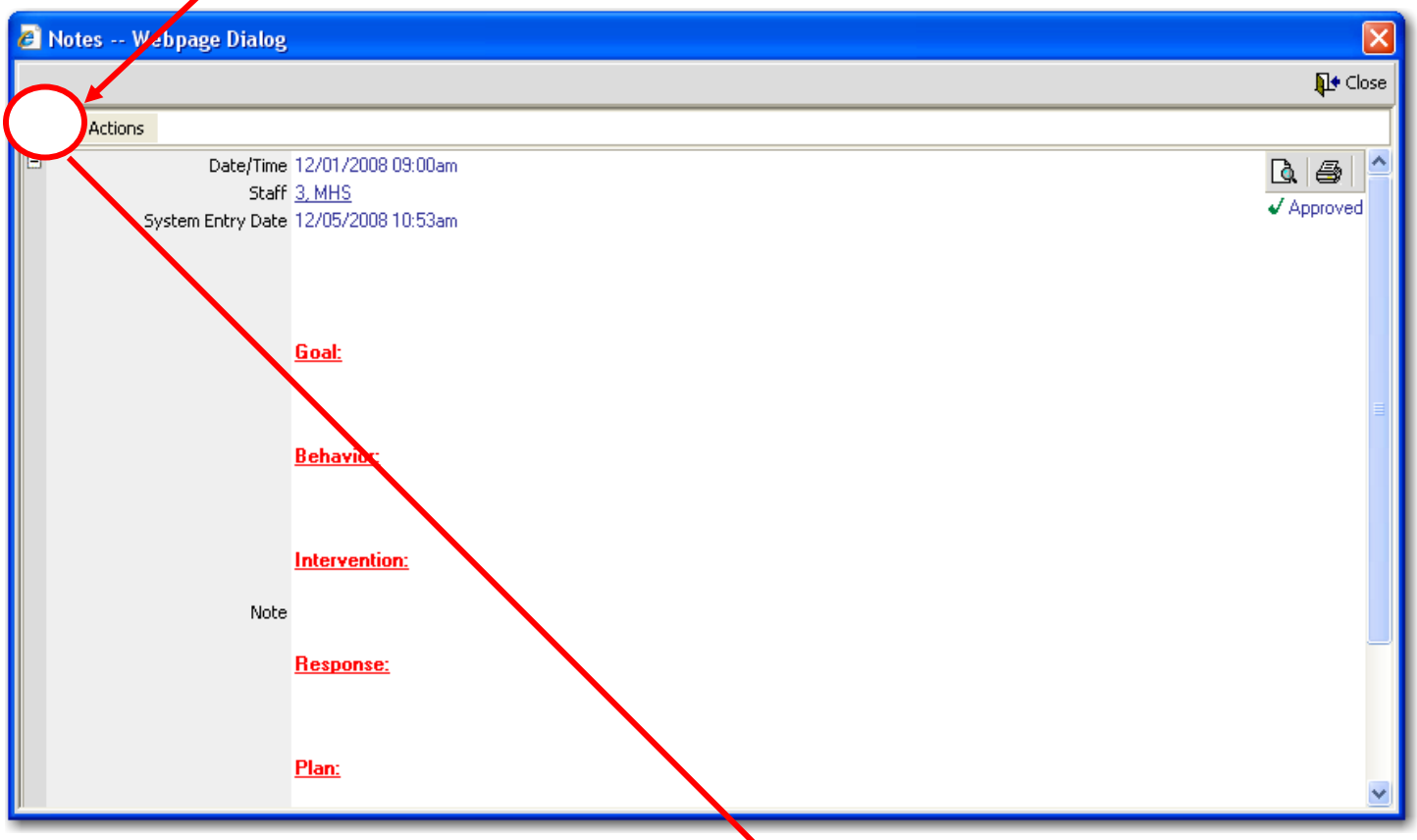
To add an addendum click on the progress note icon to the far right of the service.



A Notes box will open where you can view the original note documented.

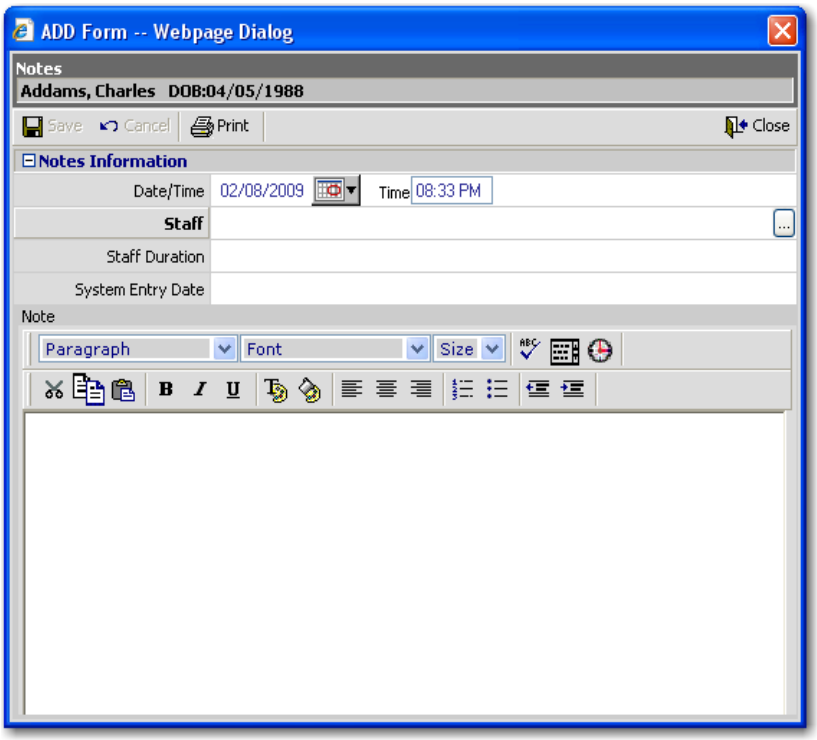


Click on the New button.

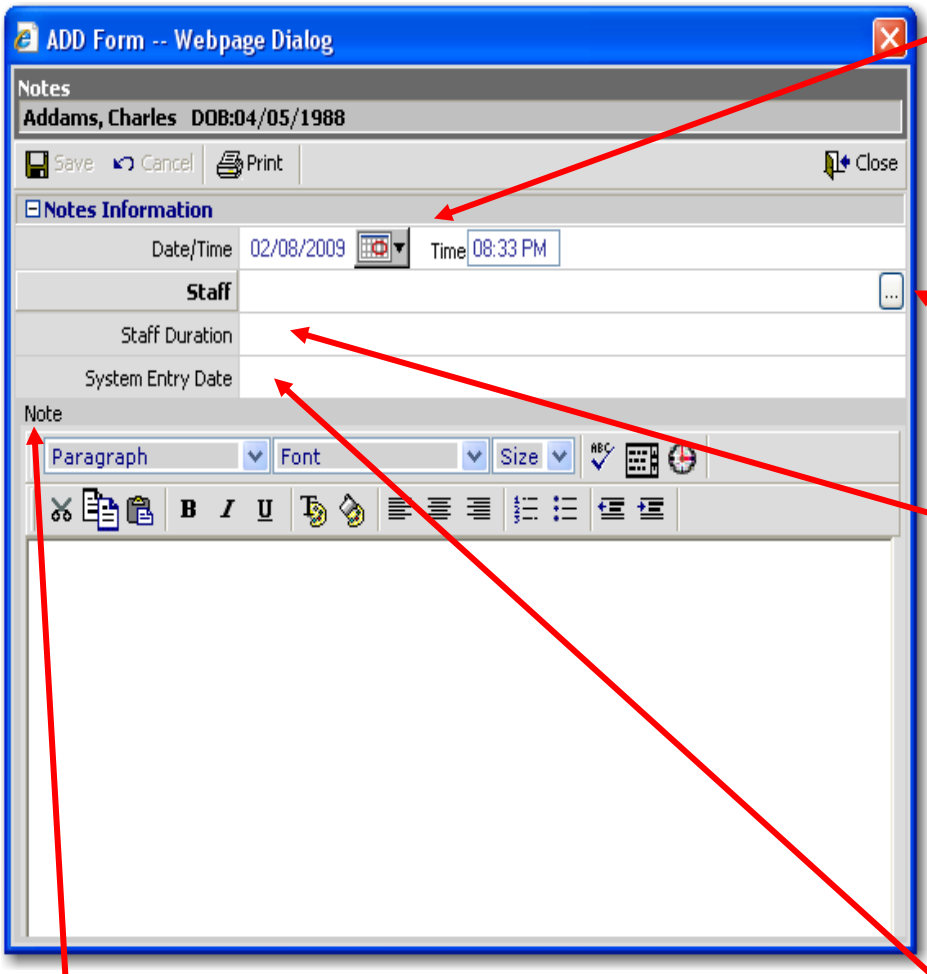


A drop down menu will open, click on Notes

A Notes box will open where you can add the addendum to your original note.



A closer look at the Notes Information section.



Date/Time: is the date and time of day the addendum is written. The system will auto-populate the current date and time. You are able to change the data if needed.

Staff: click the ellipses to the far right and select your name from the staff drop down box.

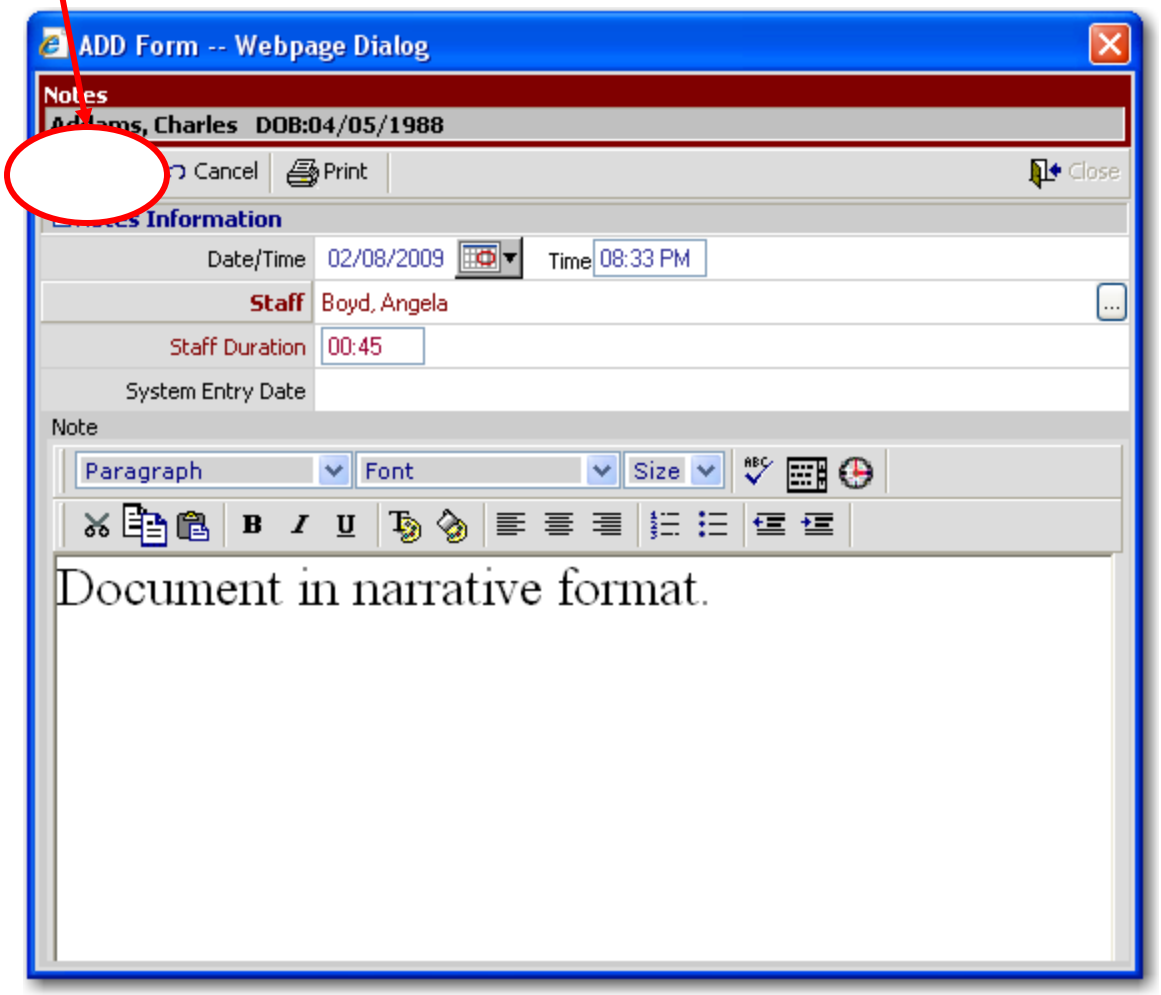
Staff Duration: enter the duration of time it took to document the addendum. Enter the duration in minutes. This time DOES NOT count toward your productivity and the time does not get billed.

- To enter the time click in the field next to the words "Staff Duration"

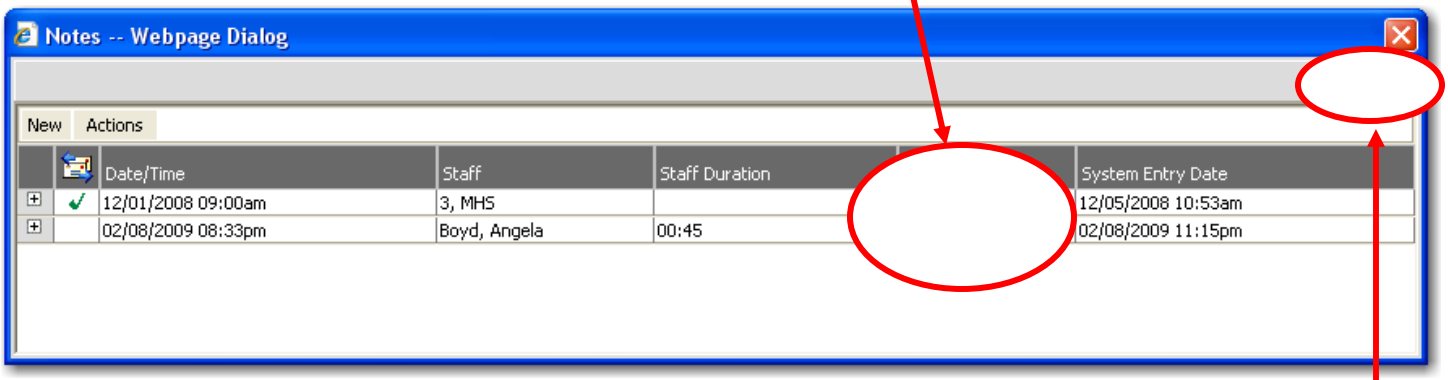
System Entry Date: not modifiable, the system auto-generates this date and time when the addendum is entered.

The Note section functions the same as outlined on page 27. An addendum to a Progress Note does not need to be written in any particular format, it can be written in narrative format.

When you have completed the Notes Information section and the Progress Note documentation click Save



The Progress Note will close and you will be brought back to the Notes box. The addendum Progress Note will show under the original Progress Note. Notice the Main Note column. The original note is the main note and the addendum is not the main note.



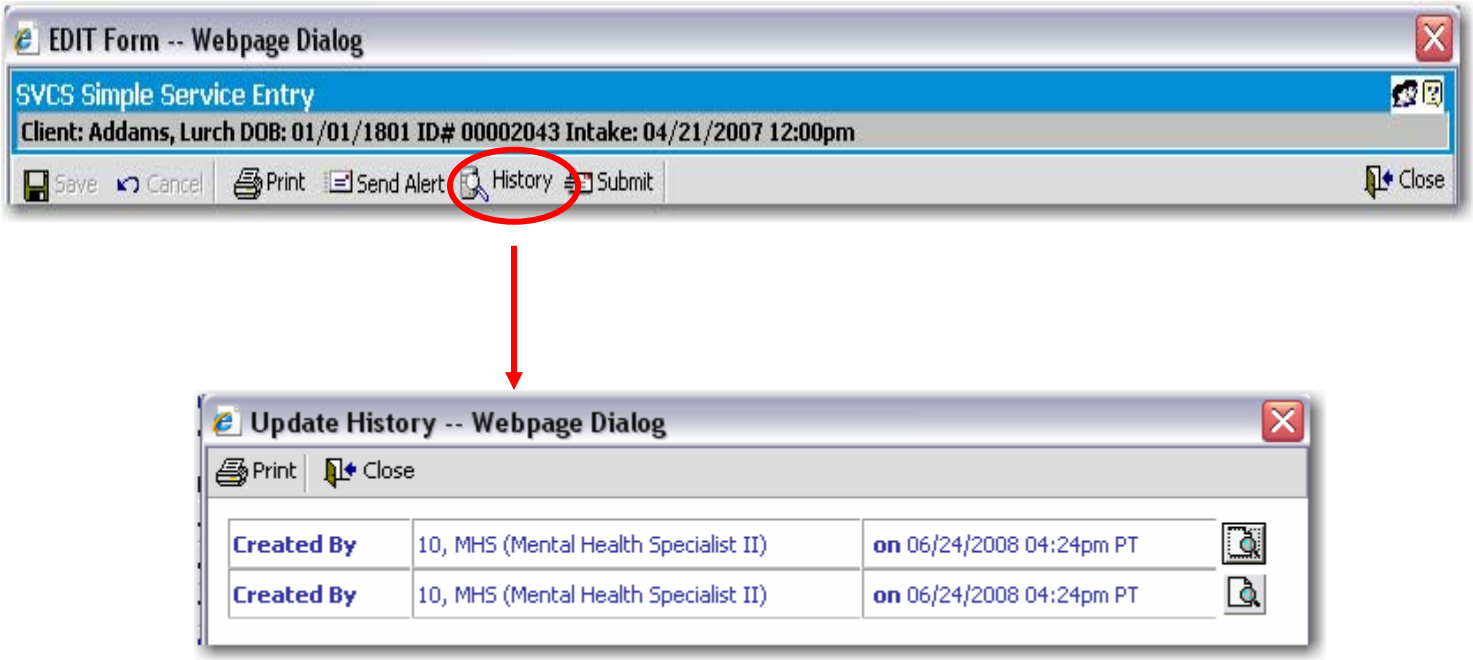
Click Close and you will be returned to the Service Entry Screen.

HISTORY BUTTON

Everything you do in the EMR leaves an electronic trail / foot print. State and County Auditors will use this trail in their audits to determine when and who provided what services and when those services were documented. Be careful with the number of times you are in and out of a service. Each time you go into a service you leave a "foot print".

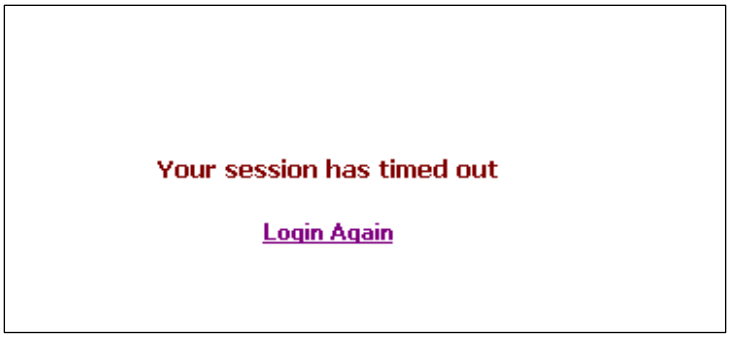
Here are the steps for viewing the history within each of the services.

1. Click into a service
2. The Simple Service Entry Screen will open
3. Click on the History button
4. A box containing the History of the specific service will open



System Time-Out - Saving Data

A **SYSTEM TIME OUT** occurs when the system automatically logs a user off because of inactivity or an unexpected disconnection from database. If you leave the EMR open ***without saving*** for more than 30 minutes the server will log you out of the EMR. You will be see the following message when you return, prompting you to login again.



If this occurs you will loose any UNSAVED data. Neither the EMR nor the IT Team will be able to recover lost data that was not saved.
Saving your services periodically will help prevent the loss of services/data. The EMR team recommends saving services every 10 mins particularly when you are working on Assessments and the Treatment Plan. To save a service you will have to complete all required fields first and then click save.

System Log out

When you are ready to end your EMR session, click on the log-out button located in the upper-right of your screen.

Do not click the Red X to close the EMR; doing so will only close your internet browser NOT your EMR session. You MUST "close the door" by clicking the log-out icon.

SEARCH TIPS

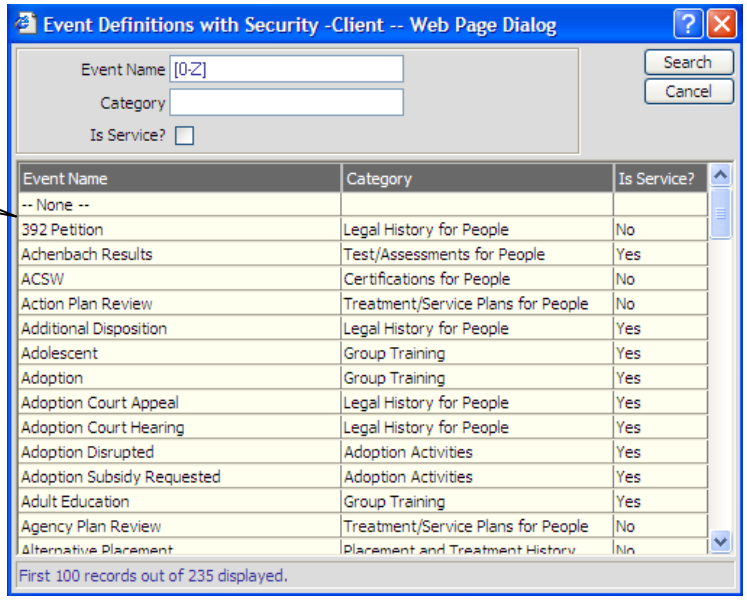
Topic: Look-Up Tables with over 100 records

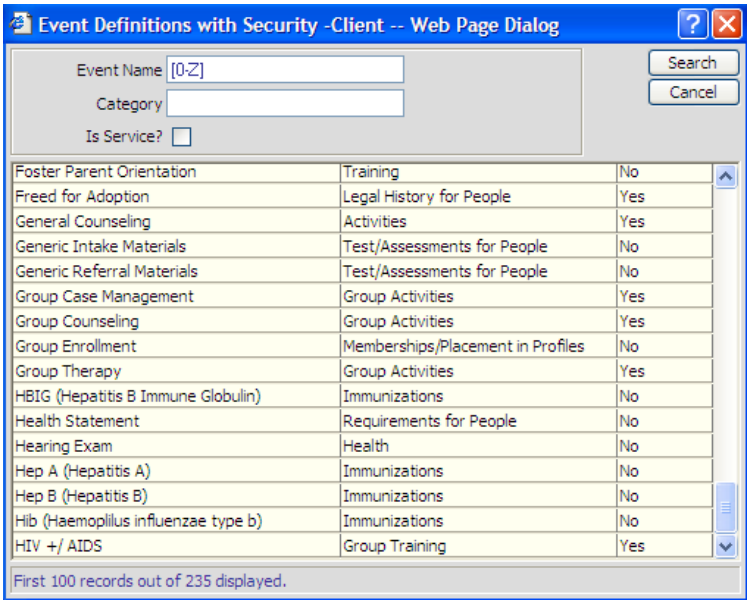
Problem: Users frequently believe that a record they are looking for does not exist or can not be found, failing to realize that pick-lists only list the first 100 records out of the total amount (if there are over 100). This is a system convention that is used in Evolv-CS to prevent potential performance issues.

Solution: If the user does not know the first few letters of a field to search on, the user can utilize different combinations of SQL keywords to filter the list.

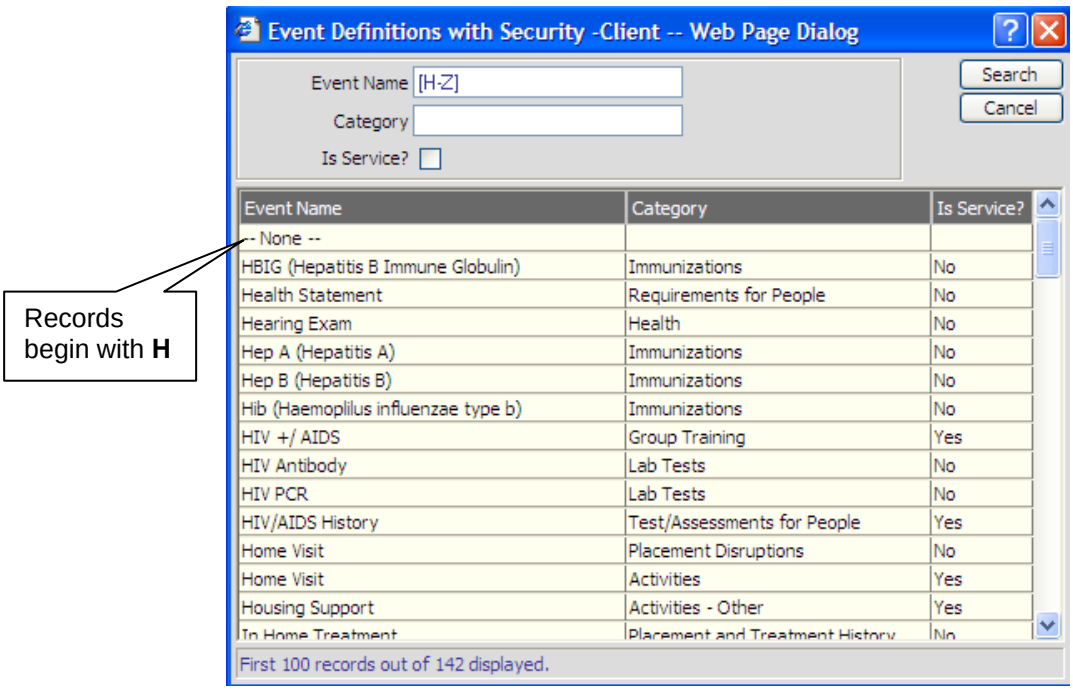
Attempt #1: **[0-Z]** (the number zero through the letter "z"; equivalent to using the **%** character as a wildcard)

Records may begin with **#s**

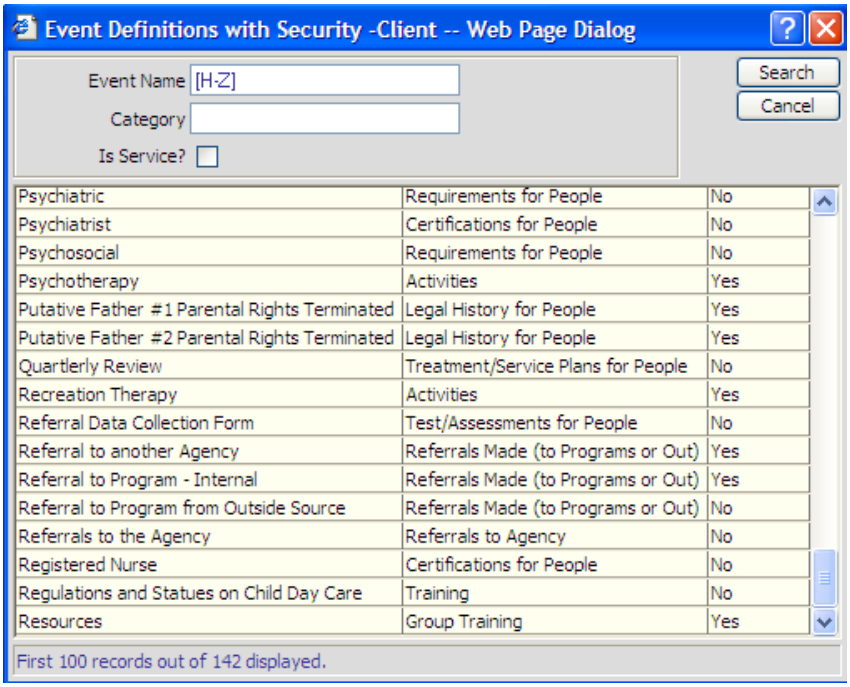

Event Definitions with Security -Client -- Web Page Dialog
Event Name [0-Z]
Category
Is Service?
Search
Cancel
Event Name | Category | Is Service?
-- None --
392 Petition | Legal History for People | No
Achenbach Results | Test/Assessments for People | Yes
ACSW | Certifications for People | No
Action Plan Review | Treatment/Service Plans for People | No
Additional Disposition | Legal History for People | Yes
Adolescent | Group Training | Yes
Adoption | Group Training | Yes
Adoption Court Appeal | Legal History for People | Yes
Adoption Court Hearing | Legal History for People | Yes
Adoption Disrupted | Adoption Activities | Yes
Adoption Subsidy Requested | Adoption Activities | Yes
Adult Education | Group Training | Yes
Agency Plan Review | Treatment/Service Plans for People | No
First 100 records out of 235 displayed.


Event Definitions with Security -Client -- Web Page Dialog
Event Name [0-Z]
Category
Is Service?
Search
Cancel
Foster Parent Orientation | Training | No
Freed for Adoption | Legal History for People | Yes
General Counseling | Activities | Yes
Generic Intake Materials | Test/Assessments for People | No
Generic Referral Materials | Test/Assessments for People | No
Group Case Management | Group Activities | Yes
Group Counseling | Group Activities | Yes
Group Enrollment | Memberships/Placement in Profiles | No
Group Therapy | Group Activities | Yes
HBIG (Hepatitis B Immune Globulin) | Immunizations | No
Health Statement | Requirements for People | No
Hearing Exam | Health | No
Hep A (Hepatitis A) | Immunizations | No
Hep B (Hepatitis B) | Immunizations | No
Hib (Haemoplilus influenzae type b) | Immunizations | No
HIV +/ AIDS | Group Training | Yes
First 100 records out of 235 displayed.

Attempt #2: **[H-Z]** ("find all values that start with H, I, J…X, Y, or Z", i.e. "h" through "z")


Event Definitions with Security -Client -- Web Page Dialog
Event Name [H-Z]
Category
Is Service?
Search
Cancel
Event Name | Category | Is Service?
-- None --
HBIG (Hepatitis B Immune Globulin) | Immunizations | No
Health Statement | Requirements for People | No
Hearing Exam | Health | No
Hep A (Hepatitis A) | Immunizations | No
Hep B (Hepatitis B) | Immunizations | No
Hib (Haemoplilus influenzae type b) | Immunizations | No
HIV +/ AIDS | Group Training | Yes
HIV Antibody | Lab Tests | No
HIV PCR | Lab Tests | No
HIV/AIDS History | Test/Assessments for People | Yes
Home Visit | Placement Disruptions | No
Home Visit | Activities | Yes
Housing Support | Activities - Other | Yes
First 100 records out of 142 displayed.

Records begin with **H**


Event Definitions with Security -Client -- Web Page Dialog
Event Name [H-Z]
Category
Is Service?
Search
Cancel
Psychiatric | Requirements for People | No
Psychiatrist | Certifications for People | No
Psychosocial | Requirements for People | No
Psychotherapy | Activities | Yes
Putative Father #1 Parental Rights Terminated | Legal History for People | Yes
Putative Father #2 Parental Rights Terminated | Legal History for People | Yes
Quarterly Review | Treatment/Service Plans for People | No
Recreation Therapy | Activities | Yes
Referral Data Collection Form | Test/Assessments for People | No
Referral to another Agency | Referrals Made (to Programs or Out) | Yes
Referral to Program - Internal | Referrals Made (to Programs or Out) | Yes
Referral to Program from Outside Source | Referrals Made (to Programs or Out) | No
Referrals to the Agency | Referrals to Agency | No
Registered Nurse | Certifications for People | No
Regulations and Statues on Child Day Care | Training | No
Resources | Group Training | Yes
First 100 records out of 142 displayed.

Attempt #3: **[R-Z]**, etc.

This makes it possible for users to filter through all possible ranges of listed records.

Service Grid

	Forms	PN Needed?	Supervisor review required	Objective Link (Treatment Context)
1	3-page Child Assessment	No	Yes	No
2	Administrative Discharge Summary/Aftercare Plan	No	Yes	No
3	Adult Initial Assessment	No	Yes	No
4	Adult Initial Assessment Addendum	No	Yes	No
5	Adult Substance Use Self Evaluation	No	No	No
6	Annual Assessment Update	No	Yes	No
7	CAFAS	No	No	No
8	Care Plan	Yes	Yes	No
9	CFE	No	Yes	No
10	Change of Diagnosis	Yes	Yes	No
11	Child Initial Assessment	No	Yes	No
12	Child Initial Assessment Addendum	No	Yes	No
13	Coordination Plan	No	Yes	No
14	Dangerous Bx Safety Plan **(supervisor completes)**	Yes	No	No
15	Dangerous Bx Screening	No	Yes	No
16	Discharge Summary/Aftercare Plan	No	Yes	No
17	Family Safety Crisis Plan	Yes	Yes	No
18	ILSS Screening	No	No	No
19	PECFAS	No	No	No
20	Permanency Placement Screening	No	No	No
21	Provisional Care Plan	No	Yes	No
22	Service Integration Team (SIT)	No	Yes	No
23	Substance Use Assessment - DD	No	No	No
24	Substance Use Parent/CG Questionnaire	No	No	No
25	Substance Use Self Evaluation - DD	No	No	No
26	Suicide Assessment	No	Yes	No
27	Suicide Safety Plan **(supervisor completes)**	Yes	No	No
28	TBS Functional Assessment	No	Yes	No
29	TBS Monthly Review	Yes	Yes	No
30	Trauma Screening	No	Yes	No
31	Treatment Team Note	No	Yes	No

	Services	PN Needed?	Supervisor review required	Objective Link (Treatment Context)
32	Case Consultation Progress Note	Yes	Yes	Yes
33	Collateral Progress Note	Yes	Yes	Yes
34	Crisis Intervention Progress Note	Yes	Yes	Yes
35	Family Therapy Progress Note	Yes	Yes	Yes
36	Individual Therapy Progress Note	Yes	Yes	Yes
37	Individual Rehabilitation Progress Note	Yes	Yes	Yes
38	N/C (No Contact) Note	Yes	No	Yes
39	Targeted Case Management Progress Note	Yes	Yes	Yes
40	TBS Progress Note	Yes	Yes	Yes

Who do I contact if I have EMR problems?

Review the EMR Decision Tree below. The "Department Responsible" columns should be read from left to right as far as who to contact first when a problem arises.
If you still need to contact the EMR Department notify your supervisor first then submit a Track-IT ticket. **NOTE:** Be descriptive of your problem in the Track-IT ticket and include details such as name of the client, date of service, name of the service, number of minutes billed, etc. The more information we receive when the problem is first reported the quicker our ability to problem solve.

EMR Decision Tree

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
Collateral not in the EMR	Clinician complete a "Collateral Information Sheet" and give it to your Center Coordinator	**X**								**Center Coordinators** enter Collateral Information in the EMR
Change a diagnosis for my client	Clinician complete a "Change of Diagnosis" form and give it to the Center Coordinator, then trigger a "Change of Diagnosis" service in the EMR, notify Psych of Diagnosis change	**X**								**Center Coordinators** change Diagnosis in the EMR *AND* the IS system
I am working with a client from a different team and need access to that client	Supervisor notifies the Center Coordinator	**X**								**Center Coordinators** add staff as a "Direct Worker" to the client in the EMR, if the staff needs access to more than one client on a particular team contact the EMR team to have the staff added to that teams workgroup
Adding work groups	NONE	**X**								**Center Coordinators** add work groups to clients

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
Adding School Information Entry	Clinician complete a "Collateral Information Sheet" and give it to your Center Coordinator	**X**								**Center Coordinators** add School information
Allotted time for billing particular services/ forms?	Clinician, contact your supervisor, the QA Dept or review the Scope of Practice Manual		**X**	**X**						**Supervisor or QA Dept.** review Scope of Practice Manual with staff
Appropriate billing codes	Clinician, contact your supervisor, the QA Dept, review the Scope of Practice Manual or review the "help" button within each service in the EMR		**X**	**X**						**Supervisor or QA Dept.** review Scope of Practice Manual with staff
Audit issues – my packet / forms are on the QA Audit list	Clinician, contact your supervisor		**X**	**X**						**Supervisor** review the audit issues with your staff, if you have any questions/problems contact the QA Dept. **QA Dept.** review the audit report with supervisors as needed
Packet questions – I am confused about the packet process	Clinician, contact your supervisor		**X**	**X**	**X**	**X**				**Supervisor** review the packet process with your staff, if you have any questions/problems contact the QA Dept. **QA Dept.** review the packet process with supervisors as needed
Problem with the Treatment Plan	Clinician, contact your Supervisor or your QA Manager/Coordinator		**X**	**X**						**Supervisor** review the packet process with your staff, if you have any questions/problems contact the QA Dept. **QA Dept.** review the packet process with supervisors as needed

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
I need more help with navigating the EMR	Clinician, contact your supervisor, if the problem can wait you can sign-up for EMR Support from the EMR Dept (sign-up sheet at the receptionist desk in each office) NOTE: Bring your EMR Manual with your for all trainings		**X**	**X**					**X**	**Supervisor** assist your staff with navigation questions, if you have any questions/problems contact the QA Dept. **QA Dept.** assist with navigation questions/problems as needed, if you have any questions/problems send a Track-IT ticket to the EMR Dept. **EMR Dept** will respond to ticket in Track-IT
EMR coverage for Supervisor's on leave	Clinician, use the "submit to" button as directed by your Supervisor and Center Director				**X**					**Center Directors** work with supervisor to instruct staff to use the "submit to" button while supervisor is out
I accidently forgot to submit my service to someone other than my supervisor	Clinician, send a Track-IT ticket to the EMR Dept.								**X**	**EMR Team** will "un-submit" service back to staff.
I am need to run reports in the EMR	NONE		**X**	**X**	**X**					**Supervisor work with the QA Dept and Center Directors** to identify relevant reports in the EMR
I keep getting logged off the EMR	Clinician, send a Track-IT ticket to IT Dept.						**X**			**IT Dept** will respond through Track-IT
I get Internet error messages when I am in the EMR	Clinician, send a Track-IT ticket to IT Dept.						**X**			**IT Dept** will respond through Track-IT
EMR is running slow	Clinician, send a Track-IT ticket to IT Dept.						**X**			**IT Dept** will respond through Track-IT

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
I need a service deleted	Clinician, contact your Supervisor			**X**				**X**		**Supervisor** follow the Deletion Policy and/or your Supervisor Handbook, request deletion from the Finance Dept NOTE: there is a difference between deleting a Claim (billing information for a service) and a service (documentation of the service provided) ***** IMPORTANT ***** Supervisors – *DO NOT* un-approve services that have already been billed (green check mark under $ column), if you need to do something with a billed service contact the Finance Dept before un-approving **Finance Dept** will delete the service AND/OR Claim as requested
Scanning packets, who do I give the packets to and when are they due	Clinician, contact your supervisor, the QA Dept., the Center Coordinator, or Medical Records Dept	**X**	**X**	**X**	**X**	**X**				**Supervisor** review the packet process with your staff, if you have any questions/problems contact the QA Dept., the Center Coordinator or MR Dept. **QA Dept., Center Coordinator or MR Dept** review the packet process with supervisors as needed
Forgot my password for the EMR or having a problem signing into the EMR	Clinician, send a Track-IT ticket to the EMR Dept.								**X**	**EMR team** will change your password and notify you of the change in Track-IT, staff is responsible for checking back in Track-IT for the disposition of the ticket

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
I need to delete a scanned packet (**only** requested by Center Coordinators or MR dept.)	NONE	**X**				**X**			**X**	**Center Coordinator / Medical Records Dept** completes a Scan Packet Deletion request form and submits it to the EMR Dept. **EMR Dept.** will delete the scanned packet upon receipt of the deletion request form
I have moved to a different team and need access to my new team	Clinician, contact your new supervisor			**X**					**X**	**Supervisor** needs to send a Track-IT ticket to the EMR team **EMR Team** will assign the staff to the new team
Unable to save a service/form, I keep getting an error message	Clinician, troubleshoot that all required fields are complete, make sure there is not any symbols (&, %, #, etc.) in the text fields, make sure that you DID NOT cut and paste from word or that you completely added information in the participants field, etc.		**X**	**X**					**X**	**Supervisor** assists staff with trouble shooting problems with saving/submitting. If you have any problems/questions contact the QA Dept. **QA Dept.** assists supervisor and staff with trouble shooting problems saving/submitting. If you have any problems /questions send a Track-IT ticket to the EMR Dept. **EMR Dept** will respond to ticket in Track-IT
I have promoted to an MHS II. I need access to the appropriate scope of practice in the EMR.	Clinician, when requested provide another signature to the EMR dept with new title/degree			**X**					**X**	**Supervisor** submits required paperwork to HR. **HR** will notify the EMR Dept when required paperwork has been received **EMR Dept.** will schedule a time to capture another signature with new title/degree with staff

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
I am having problems with the EMR on my home computer / I can't save a service or I lost forms in the EMR on my home computer or when I click the box will not open	Clinician, refer to your Home User Guide, the EMR team and IT team can not help with your home computer issues									
I can't see/find my client in the EMR	Clinician, contact your Center Coordinator	**X**								**Center Coordinator** review Enrollment information and add staff either as Direct Worker or add workgroup to the client
I am a supervisor and need more support in the EMR	Supervisor, contact your Supervisor/Center Director		**X**		**X**				**X**	**Center Director** assist supervisors with navigation questions, if you have any questions/problems contact the QA Dept. **QA Dept.** assist supervisors with navigation questions, if you have any questions/problems send a Track-IT ticket to the EMR Dept. **EMR Dept** will respond to ticket in Track-IT

Problem	Staff Responsibility	Department Responsible								Note to Department Responsible
		Center Coordinator	Quality Assurance	Supervisor	Center Director	Medical Records	IT Dept.	Finance Team	EMR Team	
I noticed an error in one of the documents scanned in the EMR	Clinician, contact your supervisor	**X**		**X**		**X**				**Supervisor** contact the Center Coordinator or Medical Records Department **Center Coordinator or Medical Records Dept.** follow the process outlined for deleting a scanned packet *NOTE:* the Center Coordinators and Medical Records Dept should be auditing the packets PRIOR to scanning, this will help reduce the number of errors and the need for deleting packets
I need Initial EMR Training	Clinician, show up ON TIME for scheduled initial EMR training								**X**	**EMR Team / Training Dept** provide Initial EMR training